Presbyterian Support Otago

3. Response to the Royal Commission Recommendations Government Legal and Other Entities to be read in conjunction with Response Document for Faith Based entities

And

the Establishment of a new Puretumu Torowhānui Scheme Response Documents

Recommendation	Response	Comments	Action Plan
Recommendation 4 The Catholic Church's principal representative in Aotearoa New Zealand, the Archbishop of Wellington and eighth ordinary of the see, should write to the Pope and the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life: a. expressing concern that brothers in the Hospitaller Order of the Brothers of St John of God who have been accused or convicted of sexual abuse and neglect in Australia and Aotearoa New Zealand have also been sent to Papua New Guinea, and little is known about the nature and extent of abuse and neglect there or the needs of potential survivors b. seeking an Apostolic visitation into the nature and extent of abuse and neglect by the Order in Papua New		For the Catholic church to respond .	

Guinea and the systemic factors leading to abuse and neglect by the Order in the Oceania province. The letter should be developed and agreed with a representative group of survivors. The letter and report from the Pope and the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life should be made public.			
Recommendation 11 Compensate survivors of abuse and neglect in care Me whakatau he utu ki ngā purapura ora i pākia e ngā mahi tūkino i roto i ngā pūnaha taurima If the government does not progress the Inquiry's recommended civil litigation reforms (Holistic Redress Recommendations 75 and 78 from the Inquiry's interim report, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui): a. the government should reform the accident compensation (ACC) scheme to provide tailored compensation for survivors of abuse and neglect in care and other appropriate remedies b. survivors should be fairly and meaningfully compensated for all	Accept		

direct and indirect losses flowing from the abuse and neglect they experienced in care and that are covered by the new puretumu torowhānui system and scheme c. the application process should be survivor-focused, trauma-informed and delivered in a culturally and linguistically appropriate manner.			
Recommendations 12–13 Order of St John of God specific actions He whakatau motuhake mō te Order of St John of God **Recommendation 12** The Bishop of the Diocese of Christchurch should write to the Provincial of the Oceania Province of the St John of God Brothers seeking: a. regular notifications of all new reports of abuse and neglect in Aotearoa New Zealand received by the Order of the Brothers of St John of God (subject to complainants' consent) b. regular notifications of all requests to reopen or reassess claims involving Aotearoa New Zealand survivors c. the Order's response to all such reports and requests. All correspondence should be made public, together with an explanation of		For the Bishop of the Diocese of Christchurch to respond	

the steps taken in response as soon as possible.			
Recommendation 13 The Bishop of Christchurch, the Provincial of the Oceania Province of the St John of God Brothers and relevant State representatives should meet and agree on what steps they can take, whether separately or together, to ensure all survivors of Marylands School, St Joseph's Orphanage and Hebron Trust in Ōtautahi Christchurch and their whānau or support networks are made aware of the puretumu torowhānui system and scheme and support options available to them.		For the Bishop of Christchurch, the Provincial of the Oceania Province of the St John of God Brothers to comment further.	
Recommendation 17 The government should regularly assess the puretumu torowhānui system and scheme against the performance indicators and publish annual reports on progress against the indicators**.**	Agree		
Recommendation 18 Review Lake Alice settlements for parity Tirohia anō mehe mea kei te ōrite ngā whakatau mō Lake Alice The government should:		For the Government to respond.	

a. appoint an independent person to promptly review all Lake Alice settlements and advise whether any further payments to claimants who have previously settled are necessary to ensure parity in light of the District Court decision in 2002 regarding the deduction of money from second round claimants for legal costs b. ensure that any payments to claimants who have not yet settled are, as a minimum, equitable in light of the review.			
Recommendation 19 Establish an independent investigation of unmarked graves and urupā Whakatūria he arotakenga motuhake mō ngā poka ingoa kore me ngā urupā The government should appoint and fund an independent advisory group to investigate potential unmarked graves and urupā at the sites of former psychiatric and psychopaedic hospitals, social welfare institutions or other relevant sites.		For the Government to respond.	
Recommendations 22-24 Amend prosecution guidelines Panonihia ngā tikanga whakawhiu-ā-ture **Recommendation 22**		Agree in principle, although noted outside of PSO's functions or expertise	

The Solicitor-General should amend the suite of prosecution guidelines to: a. include a requirement that those making decisions about whether to prosecute, and which charges to file, act consistently with New Zealand's international human rights obligations and other relevant international law obligations (including the United Nations Convention on the Rights of Persons with Disabilities, the United Nations Convention on the Rights of the Child and the United Nations Declaration on the Rights of Indigenous People) b. include, in relation to the evidential test for prosecution, a requirement that those making assessments on the credibility and quality of a complainant's evidence recognise the potential for their own bias, obtain relevant expert advice where necessary, and provide appropriate accommodations where necessary c. include, as a public interest consideration for prosecution, that the offence was committed against a person in the care of the State or a faith-based institution d. strengthen obligations to engage appropriately (that is, more than consult) with complainants (including			

the use of communication assistance) on prosecution decisions, including when considering whether to prosecute because of the likely detrimental effect on a witness's physical or mental health e. establish a review process for complainants who allege offences falling under Parts 7 or 8 of the Crimes Act 1961 where a decision has been made not to prosecute by NZ Police or a Crown Solicitor, which: i. is designed to ensure fairness and consistency in approach to charging decisions nationwide ii. requires an evaluative review of the evidence and the decision not to prosecute iii. establishes national panels of suitably trained and experienced prosecutors to conduct reviews of decisions not to prosecute made by NZ Police and Crown Solicitors iv. includes a requirement for the panel reviewing NZ Police decisions not to prosecute to seek legal advice from a Crown Solicitor where the decision is finely balanced and/or complex, or is an offence listed in the schedule to the Crown Prosecution Regulations 2013 v. has the power to refer a decision not to prosecute back to the decision			

maker for further consideration and/or investigation vi. ensures complainants are consulted in person with necessary accommodations.			
Recommendation 23 The Solicitor-General should issue specific guidelines to prosecutors on how to approach cases involving complainants, witnesses and defendants who are Deaf, disabled and/or experience mental distress to ensure access to justice, and in doing so should involve those with lived experience throughout the development process to ensure concerns and aspirations are consistently understood and considered.	Agree	Agree in principle, although noted outside of PSO's functions or expertise. .	
Recommendation 24 The government should invest in training for prosecutors on these guidelines.	Agree	Agree in principle, although noted outside of PSO's functions or expertise.	
Recommendation 25 Support judicial initiatives that address the causes of offending Tautokohia ngā tikanga-ā-ture e tohu ana ki ngā take whakamau hara The government should support and invest in judicial-led initiatives, such as	Agree		

Te Ao Mārama – Enhancing Justice for All, that recognise and address the harm caused by abuse and/or neglect in care.			
Recommendations 26-32 Criminal justice legislative changes Ngā panoni ture taihara **Recommendation 26** The government should amend the Crimes Act 1961 to specifically include disability within the definition of a vulnerable adult.	Agree		
Recommendation 27 The government should amend the Sentencing Act 2002 to: a. include, as an aggravating feature in section 9(1), the fact that a victim was particularly vulnerable arising from being in State or faith-based care or deprived of liberty b. expand the requirement for the court to consider the aggravating factors in section 9A(2) in cases of abuse and/or neglect to include children and young persons under the age of 18 years c. include a requirement that when considering an offender's previous convictions under section 9(1)(j) the court should ensure those with convictions for offences committed in		Agree in principle, although noted outside of PSO's expertise.	

response to abuse and/or neglect in care are not unduly penalised.			
Recommendation 28 The government should amend section 284 of the Oranga Tamariki Act 1989 to ensure that offending by young people abused and/or neglected in care in response to that abuse and/or neglect, is not given undue weight as an aggravating factor at sentencing for later unrelated offending.		Agree in principle, although noted outside of PSO's expertise.	
Recommendation 29 The government should review the Criminal Records (Clean Slate) Act 2004 to ensure that offending committed by people abused and/or neglected in care in response to that abuse or neglect, does not unfairly exclude them from eligibility under the Act.		Agree in principle, although noted outside of PSO's expertise.	
Recommendation 30 The government should amend section 11 of the Victims Rights Act 2002 to ensure that victims of abuse and neglect in State or faith-based care must be advised of the ability to seek redress in the civil courts and through the puretumu torowhānui system and scheme, and their right to apply for legal aid for civil proceedings.	Agree		

Recommendation 31 The Ministry of Justice should establish a list of specialist lawyers available to provide legal advice to victims about seeking puretumu torowhānui (holistic redress).	Agree		
Recommendation 32 The government should amend section 80(3) of the Evidence Act 2006 to ensure witnesses in criminal proceedings have an entitlement to apply for communication assistance to enable them to both understand the proceedings and to give evidence.		Outside of PSO's functions and expertise.	
Recommendation 33 Education and training for people involved in the justice system Te ako me te whakamatautau i te hunga e mahi ana i roto i te pūnaha-ā-ture The Ministry of Justice, Te Kura Kaiwhakawā Institute of Judicial Studies, NZ Police, the Crown Law Office, the New Zealand Law Society and other relevant legal professional bodies should ensure that investigators, prosecutors, lawyers, and judges receive education and training from relevant subject matter experts on:		Outside of PSO's functions and expertise	

a. the Inquiry's findings, including on the nature and extent of abuse and neglect in care, the pathway from care to custody, and the particular impacts on survivors of abuse and neglect experienced in care b. trauma-informed investigative and prosecution processes c. all forms of discrimination d. engaging with neurodivergent people e. human rights concepts, including the obligations under the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Elimination of all forms of Racial Discrimination, and the United Nations Declaration on the Rights of Indigenous Peoples.			
Recommendations 34-35 Amend investigation guidelines and establish a specialist investigation unit Panonihia ngā kaupapa arotake, ka whakatū ai he tira wherawhera motuhake NZ Police should review the Police Manual and other relevant material to ensure instructions and guidelines reflect and refer to Aotearoa New Zealand's international human rights		For NZ Police to comment.	

obligations and other relevant international law obligations (including the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Elimination of all forms of Racial Discrimination, and the United Nations Declaration on the Rights of Indigenous Peoples).			
Recommendation 35 NZ Police should establish a specialist unit dedicated to investigating and prosecuting those responsible for historical or current abuse and neglect in State and faith-based care.		For NZ Police to comment	
Recommendations 36-38 Civil justice legislative changes Ngā panoni ture tikanga-ā-iwi **Recommendation 36** The courts should prioritise civil proceedings regarding care or abuse and neglect in State or faith-based care to minimise litigation delays.		Agree in principle, although noted outside of PSO's functions and expertise.	
Recommendation 37 The government should review the Legal Services Act 2011 to remove barriers to civil proceedings regarding abuse and neglect in care, including		Agree in principle, although noted outside of PSO's functions and expertise.	

means testing criteria, charges over property, and repayments.			
Recommendation 38 The government should amend the following provisions of the Evidence Act 2006: a. section 80(3), to ensure that witnesses in civil proceedings have an entitlement to apply for communication assistance to enable them to understand the proceedings and give evidence b. section 103(4)(b)(ii), to require a court when making directions on alternative ways of giving evidence in civil proceedings relating abuse and neglect in care to consider the need to promote the recovery of parties and witnesses from the abuse and neglect c. subpart 5, to include provision for directions for alternative ways of giving evidence for parties and witnesses in civil proceedings where appropriate.		Outside of PSO's functions and expertise.	
Recommendation 40 National Care Safety Strategy He rautaki āhuru mōwai-ā-motu A new comprehensive National Care Safety Strategy, required by law, on the		More information required, agree in principle.	

prevention of and response to abuse and neglect in care should include: a. goals, objectives and targets that consider future generations b. clearly understood roles and responsibilities for different organisations and entities involved in the care system c. an overview of the priority programmes of work including: i. supporting and empowering victims, survivors, whānau ii. strategies to prevent abuse and neglect iii. better abuser accountability and intervention iv. improving the evidence base v. awareness raising and education vi. enhancing approaches to children, young people, and adults in care with harmful sexual behaviors			
Recommendations 41-44 Establishing an independent Care Safe Agency Te whakatū tira āhuru mōwai motuhake **Recommendation 41** The government should establish a new standalone Care Safe Agency, with an independent Board to oversee it. The Care Safe Agency should be tasked with functions that include:		Some further clarification would be helpful to understand the scope and mandate of the Care Safe Agency across state care and faith based care. Consideration to be given to existing agencies before establishing another agency that is similar to existing agencies and/or overlap the mandate.	

a. whole of system leadership on preventing and responding to abuse and neglect in care b. promoting and championing the Care Safety Principles (Recommendation 39) c. leading development and implementation of a National Care Safety Strategy and a supporting action plan to prevent and respond to abuse and neglect in care (Recommendation 40) d. setting care safety rules and standards (legislative and non-legislative) (Recommendation 47) e. monitoring and investigating compliance with the care safety rules and standards (Recommendation 47) f. enforcing penalties and sanction for breaches of the care safety rules and standards (Recommendation 47) g. developing best practice guidelines on care safety and preventing and responding to abuse and neglect in care h. investigating and reporting on complaints received directly from users of supports and services i. collating and keeping a centralised database of issues of concern, complaints, and the outcomes of investigations from all State and faith-			

based entities that provide care directly or indirectly to children, young people and adults in care, from professional registration bodies, and from independent oversight and monitoring entities (Recommendation 67–68) j. accrediting all State and faith-based entities providing care directly or indirectly to children, young people, and adults in care (Recommendation 48) k. registering staff and care workers who are not already covered by existing professional registration regimes (Recommendation 57) l. promoting a continuous improvement and learning culture in the care system, including facilitating regular forums and communities of practice and evaluation m. setting training and education standards and developing curriculums for staff and care workers n. workforce development and developing career pathways for staff and care workers (Recommendation 61) o. leading public awareness, education, and prevention initiatives (Recommendations 111–112 and 121–122) p. undertaking research, data analysis and horizon-scanning, including			

building evidence on the risk, extent and impact of abuse and neglect in care q. publishing data and statistics on complaints of abuse and neglect in care to promote transparency and measurability of outcomes r. advising government on preventing and responding to abuse and neglect in care, including where systemic deficiencies are identified. In defining the scope and functions of the independent Care Safe Agency, the government should consider the additional points made in Chapter 3 of Part 9.			
Recommendation 42 The independent Care Safe Agency should be required to report annually to a parliamentary select committee on the implementation of the Inquiry's Recommendations and its other functions.		More information would be required to understand the mandate of Care Safe Agency.	
Recommendation 43 Before the independent Care Safe Agency is established, the government should review the roles, functions and powers of other government agencies involved in the care system to identify and address any duplications or gaps.	Accept		

Recommendation 44 Until the Care Safe Agency is established, as an interim measure the government should enable the new Care System Office responsible for implementing the Inquiry's Recommendations (Recommendations 123-124) to perform the functions in Recommendation 41 above, so far as is practicable.		More information would be required to understand the mandate of Care System Office.	
Recommendations 45-46 Establishing a new Care Safety Act Te hanga ture āhuru mōwai **Recommendation 45** The government should enact a new Care Safety Act and include any legislative measures required to establish a national care safety regulatory framework and to give effect to the Inquiry's Recommendations, in particular and at a minimum: a. to embed the Care Safety Principles for preventing and responding to abuse and neglect in care (Recommendation 39) b. to require a National Care Safety Strategy to prevent and respond to abuse and neglect in care (Recommendation 40) c. to establish a new independent Care Safe Agency to lead and coordinate the		More information would be required to understand the Care Safety Act.	

care system, act as the regulatory agency, and promote public awareness of preventing and responding to abuse and neglect in care (Recommendation 41) d. to create a duty of care, and strengthen and clarify the accountabilities of all State and faith-based care providers and staff and care workers (Recommendation 47) e. to provide for the creation of care standards (Recommendation 47) f. to provide for an accreditation scheme for care providers (Recommendation 48) g. to provide for the professional registration of staff and care workers (including volunteers) who are not otherwise subject to a professional registration scheme (Recommendation 57) h. to provide for penalties, sanctions and offences for State and faith-based care providers and staff and care workers who fail to comply with statutory and non-statutory standards of care (Recommendation 47) i. to provide for mandatory reporting (Recommendation 69) j. to provide for a comprehensive and strengthened pre-employment screening and vetting regime for all			

staff and care workers (Recommendation 58).			
Recommendation 46 The government should review all legislation and regulations relating to the care of children, young people, and adults in care to identify and address any inconsistencies, gaps or lack of coherence in the relevant statutory regimes.	Agree		
Recommendation 47 Consistent and comprehensive care safety standards and penalties for non-compliance Te waihanga raupapa āhuru mōwai whānui me ngā whiu mo te kore e hāngai The government should: a. establish a duty of care in the Care Safety Act that applies to all State and faith-based entities providing care directly or indirectly for children, young people and adults in care, and staff and care workers b. provide for the Care Safe Agency to set, monitor, and enforce consistent and comprehensive care safety rules and standards (legislated and non-legislated)		More information would be required to understand the Care Safety Act.	

c. provide for a range of meaningful sanctions and penalties for individuals and State and faith-based entities providing care directly or indirectly for: i. failure to comply with the duty of care under the Care Safety Act ii. failure to comply with care safety rules and standards d. provide for offences, including significant monetary fines and imprisonment, for the most serious failures to comply.			
Recommendations 48–56 Care providers to be accredited and prioritise safeguarding He whakamana i te hunga kaitiaki me ngā tikanga noho āhuru matua **Recommendation 48** The government should: a. create a system for the accreditation of all State and faith-based entities providing care directly or indirectly for children, young people or adults in care b. provide in legislation that, unless a State or faith-based entity providing care directly or indirectly is accredited, it will not be allowed to operate and will be penalised in a manner consistent with Recommendation 47.		Accept in principle.	

Recommendation 49 The government should: a. provide for the Care Safe Agency to investigate complaints or reports of abuse or neglect in the care of registered charities, rather than requiring a separate investigation into the same wrongdoing by Charities Services b. provide for the Care Safety Act to require that registered charities that care for children, young people or adults in care must comply with care standards c. provide for deregistration of a charity from the register as one of the available suite of sanctions for non-compliance with care standards d. amend the Charities Act 2005 to ensure alignment with the Care Safety Act.		More information would be required to understand the Care Safety Agency.	
Recommendations 57-64 Staff and care workers to be vetted, registered, and well trained Ngā kaimahi me ngā kaitiaki, kia tōtika, kia āta wherawherahia, me rēhita, me tautoko, kia tika te ako **Recommendation 57** The government should create a system of professional registration for		More information would be required to understand the Care Safety Agency set up. There are existing comparable systems that may be reviewed first.	

all staff and care workers who are not already covered by a professional standards regime. The Care Safe Agency should be empowered to establish and maintain standards of training, conduct and professional development and with the power to enforce these through fitness to practice procedures. The government should consult on the scope and nature of the professional registration system and phase in the introduction of the system.			
Recommendation 58 The government should: a. provide in the Care Safety Act for a comprehensive and consistent pre-employment screening and vetting regime, so that all entities seeking to engage a person to care for children, young people or adults in care (whether as an employee, contractor, volunteer or otherwise and whether in a State or faith-based institution providing care directly or indirectly context) have timely access to comprehensive information to ensure the person is safe and suitable for the relevant role b. ensure the regime for children's worker safety checking remains fit for purpose		More information would be required to understand the Care Safety Act.	

c. consider whether to introduce a barring regime like that established by the Safeguarding Vulnerable Groups Act 2006 in the United Kingdom.			
Recommendation 61 The Care Safe Agency should develop a workforce strategy for the care sector that includes: a. ensuring there are enough people with the right skills, experiences and values to meet the needs of people in care including developing strategies to address skill gaps b. identifying training needs c. fostering positive workplace cultures where people in care and staff and care workers are valued and have their voices heard d. strengthening support, supervision and management practices e. improving workplace conditions including wellbeing, safe ratios, workloads and remuneration f. removing barriers to enter into the care workforce in a safe manner g. ensuring opportunities for professional development and career progression, including targeted measures to support career pathways for:		More information would be required to understand the Care Safety Agency. If formed, the Care Safety Agency would need to be resourced appropriately.	

i. people with lived experience of care ii. Māori, Pacific Peoples, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+ people h. measuring staff and carer wellbeing and satisfaction.			
Recommendation 68 The government should enable, in legislation, the Care Safe Agency to collate and keep a centralised database of complaints, disclosures or incidents of abuse and neglect of children, young people and adults in care, for the purposes of: a. reinvestigation, if considered necessary or appropriate b. having a whole-of-system view to ensure that: i. proven perpetrators cannot move between geographic locations, professions or care settings without detection ii. people subject to multiple unsubstantiated complaints from different geographic locations, professions or care settings can be		More information would be required to understand the Care Safety Agency. Agree in principle.	

identified and steps taken if considered proportionate and appropriate c. creating an evidence base and undertaking data analysis to create new insights into perpetrator behaviours, which can in turn inform new prevention and response strategies and practices.			
Recommendation 69 The government should introduce legislation where necessary to create a coherent mandatory reporting regime which: a. applies to all State or faith-based entities providing care directly or indirectly to children, young people and adults in care b. applies to all staff and care workers who work for the entities, outlined in (a) above, including foster parents, volunteers, chief executives, trustees, board members, clergy and lay people and people in religious ministry who receive disclosures of abuse and neglect during religious confession c. ensures obligations are clear, consistent, established in legislation and should include protections from liability for those making good faith notifications		More information would be required to understand this recommendation , agree in principle.	

d. ensures access to timely advice on reporting obligations.			
Recommendations 70–75 Institutional environments and practices to be minimised and ultimately eliminated Ngā wahi tiaki me ōna tikanga kia iti iho te mana, kia kore rawa atu rānei a tōna wa **Recommendation 70** The government should prioritise and accelerate current work to close care and protection residences, which perpetuate the institutional environments and practices that led to historic abuse and neglect in care.		Consideration should be given to person's choice of care. Further definition of Institutional environments and practices in the context of contemporary Aged Residential Care would be helpful to understand this recommendation.	
Recommendation 71 The government should, as a priority, support and invest in the development of disability and mental health, educational and youth justice models of care that do not perpetuate the institutional environments and practices including segregation that led to historic abuse and neglect in care.		Safe and appropriate care for all vulnerable people should be a priority as well as focusing on being able to meet each of their needs specific to their situation and resources available.	
Recommendation 72 The government should take steps to ban pain compliance techniques in any care setting for children or young people and adults in care.	Agree		
Recommendation 73		More information needed as to what restrictive practices are being referred to. Accept restraint minimisation is central to good clinical practice in Aged Residential Care	

The government should ensure there are adequate frameworks in place to govern the use of restrictive practices for children or young people and adults in care to minimise the use of those practices (ensuring they are used only as a last resort) and provide for adequate safeguards and checks.			
Recommendation 74 The government should prioritise and accelerate work to minimise and eliminate solitary confinement in all care settings as soon as practicable, with an emphasis on person-centred and culturally appropriate approaches to reduce the use of solitary confinement safely.	Agree	Agree that an emphasis on person-centred and culturally appropriate approaches should be embedded and solitary confinement minimized and eliminated where possible.	
Recommendations 76–80 People in care are empowered and supported Me whakamana, me tautoko te hunga kei ngā pūnaha taurima **Recommendation 76** The government should: a. provide sufficient investment to enable children, young people, and adults in care to have access to an independent advocate of their choosing to support them to		Aged Care Residents have whānau and medical care service providers already. Need to know more about how this would work, agree in principle.	

understand and exercise their rights, specifically: i. each child, young person and adult in care and protection, youth justice, disability and mental health settings should have access to an individual independent advocate ii. children and young people in State, State-integrated and private schools should have access to at least one independent advocate per school b. provide that independent advocates: i. have appropriate communication skills (including for Deaf and disabled people in care) ii. be independent from the care provider and staff and care workers iii. be independent from their direct and immediate whānau of the person in care iv. proactively and regularly engage with the person in care, be available to respond in times of need, support the person in care when they need to raise issues with their carer, advocate for the right conditions, and/or generally provide peer support v. have no power over the individual			

c. provide that advocates are subject to the same regulatory standards and safeguards, including vetting, registration and training as other staff and care workers.			
Recommendation 77 The Care Safe Agency should develop a career pathway for people with previous lived experience of care towards becoming an independent advocate.		More information required to consider this.	
Recommendation 84 The government should consider, in consultation with the Privacy Commissioner, whether existing information sharing provisions are sufficient to enable adequate sharing of information to prevent and respond to abuse and neglect in care, or whether additional tools are needed. This work should consider the Recommendations of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse, "establishing a national information exchange scheme across sectors". The purpose of the review should be to ensure all bodies (whether State or non-State) providing care to children, young people or adults can access the information they need to prevent and	Agree		

respond to abuse and neglect. The review should consider, among other things, whether non-State bodies should be empowered to share information more readily with both State and non-State bodies to prevent and respond to abuse and neglect.			
Recommendations 85–87 Independent oversight and monitoring is coherent and well-resourced He taurite me te whai rawa i ngā mahi aroturuki Motuhake **Recommendation 85** The government should: a. review the roles, functions and powers of independent monitoring and oversight entities to identify and address any unnecessary duplication and encourage collaboration b. consolidate the existing care and protection and youth justice independent monitoring and oversight entities into a single entity.	Agree		
Recommendation 86 The government should ensure that there are no unreasonable barriers preventing all responsible oversight bodies from investigating complaints, proactively monitoring the care system, and collaborating as appropriate to		It is not clear what are “responsible oversight bodies”.	

enable a whole of system view, including: a. reviewing and addressing any barriers or constraints in the entities' enabling legislation, and b. ensuring the entities are adequately resourced.			
Recommendation 87 The responsible oversight bodies should: a. investigate complaints about care workers, State and faith-based care providers and/or the Care Safe Agency, including both proactive and reactive site visits b. proactively monitor the way in which State and faith-based care providers and the Care Safe Agency investigate and respond to complaints c. proactively monitor the care system, including collaboratively to ensure a whole of system view, as appropriate d. publish reports on their activities including on the outcomes of specific investigations or other monitoring functions e. share information with the Care Safe Agency, including:		It is not clear what are "responsible oversight bodies".	

i. data, statistics and other information about the prevalence and nature and extent of abuse and neglect in care ii. insights about abuse and neglect in care including the effectiveness of different practices to prevent and respond to abuse and neglect in care iii. refer the results of their investigations and other monitoring functions to enforcement or regulatory bodies including NZ Police, the Charities Commission or the Care Safe Agency.			
Recommendations 111–116 Communities are empowered to minimise the need for out of whānau care He whakaāhei i ngā whānau ki te āta aukati i ngā mahi kaitiaki i waho i te whānau **Recommendation 111** The government should invest in a nationwide social and educational campaign to address attitudes and beliefs that contribute to harmful and discriminatory experiences in care and promote positive understanding and awareness of the diversity of experiences in Aotearoa New Zealand. This campaign should focus on addressing:	Agree		

a. negative attitudes towards children and young people b. attitudes reflective of discrimination based on race, gender and sexuality c. attitudes reflective of eugenics, ableism and disablism.			
Recommendation 112 The government should invest further in nationwide social and educational campaigns to: a. challenge myths and stereotypes about abusers, bystanders and survivors of abuse and neglect in care b. help victims and survivors of abuse and/or neglect, and their whānau and support networks, to minimise shame and self-stigma, and recognise the abuse and/or neglect was not their fault and to safely disclose and report as soon as possible c. help people understand what constitutes abuse and neglect d. help people recognise the signs of abuse and neglect e. help people recognise grooming and other inappropriate behaviour f. help people understand how to respond appropriately to abuse and neglect, including complaints, reports and disclosures.	Agree		

Recommendation 114 The government should: a. accelerate and prioritise current policy and legislative work to enable children, young people and adults in care and their whānau to more effectively participate in decisions that affect them, and to bring the strength of communities into decision-making b. review legislation, policy, investments, operational practice and guidelines related to the care of children, young people, and adults in care to identify opportunities to enable children, young people and adults in care and their whānau to more effectively participate in decisions that affect them, and to bring the strength of communities into decision-making.	Agree		
Recommendation 115 The government should prioritise and invest in work to support contemporary approaches to the delivery of care and support, including devolution, social investment, whānau-centered and community-led approaches, such as Enabling Good Lives and Whānau Ora, and avoid the State-led models that	Agree	Care needs to be well resourced to work well and to meet what will be extra requirements and compliance.	

contributed to historical abuse and neglect in care.			
Recommendation 116 Commissioners Erueti and Gibson consider the government should: a. develop, plan for, and establish an independent entity, as soon as possible, responsible for: i. commissioning care and protection, youth justice, community mental health, disability and preventative services and supports from self-identified local (or in some cases, national) community groups and organisations (including hapū, iwi, urban Māori authorities, NGOs, Pacific, disability, mental distress communities, faith-based entities, and other collectives) across Aotearoa New Zealand ii. monitoring and evaluation of the delivery of care and protection, youth justice, community mental health, disability and preventative services and supports by local community groups and organisations to ensure that they are meeting the needs of individuals and whānau in their communities iii. investing in local community groups and organisations to build their		More information will be required to fully understand this recommendations. Additional resourcing will need to be provided. Recent reduction of resourcing from Oranga Tamariki resulted in much needed services either being reduced or ceased altogether. If we want to keep children out of care, we need to have support in the community for families.	

capacity and capability to design and deliver these supports and services to meet the needs of their communities iv. reporting to government, Parliament and the public on the delivery of care and protection, youth justice, community mental health, disability and preventative services and supports by local community groups and organisations to ensure that they are meeting the needs of individuals and whānau in their communities v. provide sufficient and sustainable investment to the Commissioning Agency to enable it to commission care and protection, youth justice, community mental health, disability and preventative supports and services that will meet the needs of individuals and whānau nationwide c. transfer responsibility and investment for commissioning the following services and supports to the Commissioning Agency: i. care and protection supports and services, from Oranga Tamariki ii. youth justice supports and services, from Oranga Tamariki iii. community mental health supports and services, from the Ministry of Health/Health New Zealand Te Whatu Ora			

iv. disability supports and services, from Whaikaha v. preventative supports and services, from Te Puni Kōkiri/Whānau Ora commissioning entities.			
Recommendation 117-120: Giving effect to te Tiriti o Waitangi and human rights Te whakamana i te Tiriti o Waitangi me ngā mōtika tāngata **Recommendation 117** The government should partner with Māori to give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples in relation to the development of strategy, policy, design, implementation and direct or indirect delivery of care functions, including where it has passed on its authority or care functions to any faith-based institution, or to any other individual, entity, or service provider (whether by delegation, contract, licence, or in any other way).	Accept		
Recommendation 118 All entities providing care directly or indirectly on behalf of the State or faith-based entities should:	Accept		

a. uphold the rights of Māori in care as indigenous peoples of Aotearoa New Zealand in accordance with United Nations Declaration on the Rights of Indigenous Peoples b. uphold the rights of Māori, Pacific Peoples, and people from other linguistically or culturally diverse backgrounds in care, in accordance with the Convention on the Elimination of All Forms of Racial Discrimination c. uphold the rights of girls and women in care, in accordance with the Convention on the Elimination of All Forms of Discrimination against Women d. uphold the rights of Deaf and disabled people and people who experience mental distress in care, in accordance with the Convention on the Rights of Persons with Disabilities and the Enabling Good Lives principles, including: i. recognition that Deaf and disabled people, and people who experience mental distress, in care have: - the same rights as others in care to make decisions that affect their lives, including adults having decision-making supports as appropriate			

- the right to communication assistance in making and participating in decisions that affect them, communicating their will and preferences, and developing their decision-making ability - the right to access and use advocacy services in making and participating in decisions and communicating their will and preferences ii. recognition that tāngata Turi, tāngata whaikaha and tāngata whaiora Māori and Pacific Peoples who are Deaf, disabled or experience mental distress may experience barriers to accessing supports and services due to cultural, language and other differences, and that these barriers need to be addressed. e. uphold the rights of the child in care, including: i. acting with the best interests of the child as a primary consideration, consistent with the United Nations Convention on the Rights of the Child ii. recognising the right of whānau Māori, hapū and iwi to retain shared responsibility for the wellbeing of tamariki and rangatahi Māori,			

consistent with the United Nations Declaration on the Rights of Indigenous Peoples.			
Recommendation 119 The government should review Aotearoa New Zealand's human rights framework to ensure it adequately addresses abuse and neglect in care, including: a. a stand-alone right to security of the person in the New Zealand Bill of Rights Act 1990 b. ensuring statutory protection in a Disability Rights Act of the rights of disabled people to be free from abuse and neglect in care and the relevant rights in the Convention on the Rights of Persons with Disabilities c. providing statutory protection of the rights of Māori to be free from abuse and neglect in care and the relevant rights in the United Nations Declaration on the Rights of Indigenous Peoples d. making any necessary amendment to the Human Rights Act 1993 to address abuse and neglect in care e. the provision of effective implementation of the relevant rights, including positive duties.	Agree		

Recommendation 120 The government should establish performance indicators for all entities providing care directly or indirectly on behalf of the State or faith-based entities based on Aotearoa New Zealand's domestic and international obligations. **Recommendations 121-122** Targeted abuse and neglect prevention programmes He aronga tūturu ki ngā kaupapa ārai mahi tūkino **Recommendation 121** The government should support and adequately invest in: a. programmes for children, young people and adults who are in care or are at risk of being placed in care that are delivered through community organisations, and preschool, primary, and secondary schools including kura kaupapa, private, charter and State integrated schools, that aim to increase knowledge about abuse and neglect and build their skills and tools to help them to protect themselves (both in person and online safety), including a focus on:	Agree	As previously stated, care needs to be resourced well so any new requirements for delivery of care or compliance is met.	

i. recognising grooming and other inappropriate behaviour ii. understanding what constitutes abuse and neglect iii. recognising the signs of abuse and neglect iv. understanding their rights and how they should be treated v. understanding respectful and appropriate behaviour and relationships vi. what to do and where to get help if you have concerns. b. programmes to help support parents, whānau and caregivers delivered through day care, preschool, school, sport and recreational settings, and other institutional and community settings to increase knowledge of abuse and neglect and its impacts and build skills to help reduce the risks of abuse and neglect.			
Recommendation 122 The government should support and adequately invest in: a. abuse and neglect prevention programmes, including for those who may be at risk of perpetrating abuse and neglect	Agree		

b. access to specialist support, including rehabilitation programmes, for children, young people and adults who exhibit harmful or abusive behaviours or are at risk of abusing others, including concerning or harmful sexual behaviours c. online information and a helpline to provide support for those concerned about: i. an adult they know may be at risk of perpetrating abuse and/or neglect ii. a child or young person or adult in care they know may be at risk of abuse and/or neglect iii. a child, young person, or adult in care they know may be displaying potential abusive behaviours.			
Recommendations 123-124 Establishing a Care System Office to lead implementation Te whakatū Tari Pūnaha Āhuru Mōwai motuhake hei arataki i te kaupapa **Recommendation 123** The government should establish a Care System Office later to become the Ministry for the Care System that: a. is independent from, and has no association with, the government agencies currently involved in the care		More information about how this would work would be helpful. There may be very skilled people doing a good job who could be an asset so not sure why there is a blanket decision not to employ them.	

system (including those involved in historic claims processes and in implementing the Holistic Redress Recommendations in the Inquiry's interim report He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui) b. is set up within one of the central agencies (the Treasury, Te Kawa Mataaho Public Service Commission or the Department of the Prime Minister and Cabinet) as a departmental agency c. does not employ senior officials or middle management who have been involved in the care system as described in (a) above.			
Recommendation 124 The new Care System Office should be responsible for: a. leading the implementation of the Inquiry's Recommendations set out in this report and the Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui b. leading and coordinating the work of government agencies involved in the care system c. establishing and then monitoring the independent Care Safe Agency		More information to understand how this office will work alongside the other new initiatives being proposed e.g. Care Safety Agency would be helpful. Care would need to be taken to ensure there is not more bureaucracy that doesn't necessarily result in positive outcomes but may instead be more about compliance.	

d. enacting and then administering the Care Safety Act e. providing whole of system advice to government on the care sector, settings and system.			
Recommendation 128 All public awareness, training and education programmes to identify and prevent abuse and neglect, and address prejudice and discrimination Whakatū kaupapa hautū aronga ako me te whakamātau i te iwi whānui kia mōhio me te ārai i ngā mahi tūkino, whakahāwea, whakaiti tangata **Recommendation 128** In implementing all Recommendations relating to public awareness and training and education programmes, the government and faith-based entities should ensure that these programmes include: a. preventing, identifying and responding to abuse and neglect, including: i. challenging myths and stereotypes about abusers, bystanders and survivors of abuse and neglect in care	Accept	Systems and resourcing to provide support will need to be in place and available. .	

ii. helping victims and survivors of abuse and/or neglect, and their whānau and support networks, to minimise shame and self-stigma, and recognise the abuse and/or neglect was not their fault and to safely disclose and report as soon as possible iii. understanding what constitutes abuse and neglect iv. recognising the signs of abuse and neglect v. recognising grooming and other inappropriate behaviours vi. how to respond appropriately to abuse and neglect, including complaints, reports and disclosures b. addressing prejudice and all forms of discrimination, including: i. racism ii. ableism and disablism iii. sexism iv. homophobia and transphobia v. negative attitudes towards children and young people.			
Recommendation 129 New entity appointments to reflect diversity, survivor experience and expertise	Accept		

Ko ngā kaimahi o tēnei tari me whai pukenga whānui, wheako purapura ora, e hua ai ngā pānga ki te Tiriti o Waitangi The government should ensure, in implementing the Recommendations in the Inquiry's final report and the Holistic Redress Recommendations in He Purapura Ora, he Mara Tipu: From Redress to Puretumu Torowhānui, that appointments to governance and advisory roles: a. appropriately reflect survivor experience and expertise b. appropriately and proportionately reflect the diversity of people in care c. give effect to te Tiriti o Waitangi.			
Recommendations 130–138 Transparency and public accountability for implementing Inquiry Recommendations Kia mārama, kia pono ki ngā whāinga tūmatanui e hua ai ngā tūtohinga o tēnei pakirehua **Recommendation 130** The government and faith-based institutions should publish their responses to this report and the Inquiry's interim reports on whether they accept each of the Inquiry's findings in whole or in part, and the reasons for any disagreement. The	Accept	Formal statement and apology from PSO in September acknowledging the outcome of Whanaketia. Working on publishing formal response to each Recommendation within 4 months.	

responses should be published within two months of this report being tabled in the House of Representatives.			
Recommendation 131 The government and faith-based institutions should issue formal public responses to this report about whether each Recommendation is accepted, accepted in principle, rejected or subject to further consideration. Each response should include a plan for how the accepted Recommendations will be implemented, the reasons for rejecting any Recommendations, and a timeframe for any further consideration required. Each response should be published within four months of this report being tabled in the House of Representatives.		Working on publishing formal response to each Recommendation within 4 months.	
Recommendation 132 The government should seek cross-party agreement to implement this Inquiry's Recommendations.	Agree		
Recommendation 133 The government, faith-based institutions and any other agencies that implement the Inquiry's Recommendations should:	Accept		

a. publicly report on the implementation of the Inquiry's Recommendations contained in the final report and all previous interim reports, including the implementation status of each Recommendation and any identified issues and risks b. publish the implementation report annually for at least 9 years, commencing 12 months after the tabling of this report in the House of Representatives and provide a copy to the Care System Office and Care Safe Agency.			
Recommendation 134 The annual implementation reports should be submitted to and considered by a parliamentary select committee.		More specifics required.	
Recommendation 135 The government and faith-based entities should implement the Inquiry's Recommendations within the timeframes described in this report, whilst ensuring there is open and transparent communication with communities with whom they are co-designing the future arrangements for care.		We will do our utmost to meet deadlines.	

Recommendation 136 The government should initiate an independent review to be completed by 9 years after the tabling of the final report. This review should: a. establish the extent to which the Inquiry's Recommendations have been implemented 9 years after the tabling of the final report b. examine the extent to which the measures taken in response to the Inquiry have been effective in preventing abuse and neglect in care, improving the responses of all entities providing care directly or indirectly to abuse and neglect in care and ensuring that victims and survivors of abuse and neglect in care obtain justice, treatment and support c. advise on what further steps should be taken by governments and all entities providing care directly or indirectly to ensure continuing improvement in policy and service delivery in relation to abuse and neglect in care.	Accept		
Recommendation 137 The government's implementation reports, and the independent 9-year review should be tabled in the House of Representatives and referred to a	Accept		

parliamentary select committee for consideration.			
Recommendation 138 The government and faith-based institutions should publish formal responses to the independent 9-year review, indicating whether its advice on further steps is accepted, accepted in principle, rejected or subject to further consideration. Each response should include a plan for how the accepted Recommendations will be implemented, the reasons for rejecting any Recommendations, and a timeframe for any further consideration required. Each response should be published by 31 December 2033.		We need further clarification as to what this means. If it is in relation to other recommendations that may come later, we agree in principle.	