# ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
# STATE INSTITUTIONAL RESPONSE HEARING

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| **Under** | The Inquiries Act 2013 |
| **In the matter of** | The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions |
| **Royal Commission:** | Judge Coral Shaw (Chair)<br>Dr Anaru Erueti<br>Ali'imuamua Sandra Alofivae<br>Paul Gibson<br>Julia Steenson |
| **Counsel:** | Mr Simon Mount QC, Ms Kerryn Beaton QC, Dr Allan Cooke, Ms Katherine Anderson, Ms Anne Toohey, Ms Tania Sharkey, Mr Michael Thomas, Ms Ruth Thomas, Ms Kathy Basire, Mr Winston McCarthy, Ms Julia Spelman, Ms Alice McCarthy and Ms Natalie Coates for the Royal Commission<br><br>Ms Rachael Schmidt-McCleave, Mr Max Clarke-Parker, Ms Julia White for the Crown<br><br>Ms Victoria Heine QC for the Office of the Children's Commissioner<br><br>Ms Sally McKechnie for Te Rōpū Tautoko, the Catholic Bishops and congregational leaders<br><br>Mr David Stone for the New Zealand State Abuse Survivors Charitable Trust |
| **Venue:** | Level 2<br>Abuse in Care Royal Commission of Inquiry<br>414 Khyber Pass Road<br>AUCKLAND |
| **Date:** | 15 August 2022 |

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## TRANSCRIPT OF PROCEEDINGS

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**Hearing opens with karakia tīmatanga and waiata by Kaumatua**

**[9.51 am]**

**KAUMATUA:** Nau mai e te mauri awatea, ūhia mai tō hā ki ēnei mauri ora. Unuhia te pō uriuri, pō hāngū ki roto i te tuhi kai te aranga mai te ra. Uruhi, uruhi te moana totoro. Te uruhina, tākiri te puata kaipō. Irā, mai te haeata ki ēnei tauira, te kōmako, ēnei manu ā-ora. Te wā tēnei ki te tūrama roa, te āio nuku, te pūtaketake o te hauangiangi e taiāwhio nei i ngā pū o te ihu nui, te ihu roa. Tau mai ō rongo hau, tākiri ata, ka pō, ka ea, ka ao, ka awatea ai. Nau mai e te ao, kawea mai ngā hua o tēnei rā hei whakamātau atu, hei whakamātau mai. Nau mai, tau mai, whakapūmautia te hau oranga o ēnei hautū tangata i ngā tōpito o runga, o raro o roto o waho o ēnei piringa o te mauri matatū, o te ngākau ohooho, me te hinengaro, o wai tuawhakarere, tū pakari e, rangahia e te uri. Whārō, tītokona [kia] kia tau pai, kia piki te kaha, piki te ora, piki te māramatanga e ō e, kaihia. Ka tū tārewa ki te rangi. Uwhi, wero, tau mai te mauri, kia eke panuku, kia eke Tangaroa, whano, whana haramai te toki o haumi e hui e tāiki e. Maungakiekie te maunga, Waitematā te moana, Ngāti Whātua Ōrākei te mana whenua e mihi ana, e mihi ana tēnā koutou x 3. Nei rā ka whakatau atu i a koutou kua tae ake nei ki tēnei o ngā kaupapa whakaharahara, ā, ki a koutou haere mai nei ki te whakaputa whakaaro ki te whakaputa kōrero ki te whakarongo kōrero e mihi ana ki a koutou tēnā koutou, ki a koutou o te tēpu e mihi ana ki a koutou ki ngā Kaikōmihana, heoi anō ngā kanohi o ngā tari kāwanatanga kua tae, ngā kaihautū anō. Ko te mea nui ko koutou ngā purapura ora tēnei te kaupapa o tēnei hui ko ngā purapura ora rātou i tū ki mua ai. Koutou e mātakitaki mai ana ā-ipurangi mai e mihi ana ki a koutou, ā, tēnā koutou, tēnā koutou kia ora anō huihui tātou katoa ko tō tātou nei waiata, Te Aroha. (Waiata Whakataka Te Hau).

(Te reo Māori - Welcome in light energy, shield these life forces with your spirit, dispel the intense darkness, the passive darkness for as it is written, the sun will rise. Propel towards the outstretched ocean. Enter the breaking dawn to consume the darkness, as from the ray of light to the bellbird, symbol of vitality, this is the time of extended light, tranquil earth, and source of circling gentle breezes blown from the source of the great nose, the long nose. Settle here your calm breath, to the breaking dawn, from the darkness, rising, then to the daylight. Welcome light, bring forth the fruits of the day's trials and tribulations. Welcome to settle and secure the well-being of these commanders from above and below, within and without, for these connections of enduring life force, of awakened hearts and minds, of ancient waters, firmly entrenched, raised up by the darkness. Stretch forth, prop up, be settled, be strengthened, be revived, be enlightened, make room for it, overcome it.

Elevate it skywards, envelope and pierce it, let in the life force to successfully overcome and embark upon Tangaroa, proceed to bring forth the axe, join it, secure it, unite it.

From One Tree Hill to Waitematā ocean, Ngāti Whātua as tribal authority extends greetings to you all. My purpose here is to welcome those of you who have arrived to particpate in these momentous proceedings, also, to acknowledge those of you who are here to express your views, and opinions and also hear what is to be shared, with that I welcome each and everyone here. To the panel, you the Commissioners, welcome, I also acknowledge the representatives from the government departments, including the executive officers. Importantly, to you the survivors, the purpose for this proceeding, as well as those survivors who have stood previously. To you all who are here watching, or from online, welcome, to everyone gathered here, my salutations. Our song will be Te Aroha. (Waiata Te Aroha). Those connections that bind the dead to the dead, allow them to remain in their realm and us to the living. I welcome and greet you all).

**CHAIR:** E ngā mana, e ngā reo, e ngā hau e whā, tēnā koutou, tēnā koutou, tēnā tātou katoa. E tika ana ki te mihi atu ki a koutou katoa. Tuatahi, e te mihi ana ki te mana whenua, Ngāti Whātua Ōrākei, tēnā koutou e tautoko ana i tēnei kaupapa hui. E mihi ana ki a koutou ngā purapura ora, koutou i rongohia te mamae, kia kaha, kia manawanui, kia māia. E mihi ana hoki ki a koutou e mātakitaki mai ana, e whakarongo mai ana, tēnā koutou, kia ora anō tātou katoa. (I extend my greetings to all authorities, speakers, and those from near and far. It is fitting to acknowledge you all. First I wish to acknowledge Ngāti Whātua tribal authority, thank you for the support you lend to the circumstances of this gathering. I salute you the survivors, for the pain you have suffered, be strong, resolute and brave. I also address those of you watching and listening. Greetings to everyone in attendance).

Good morning to everybody, I welcome everybody here. I recognise the mana whenua, Ngāti Whātua Ōrākei, thank you for supporting this important kaupapa.

I acknowledge all of the survivors who have experienced hurt whilst in care. Be strong-hearted. I acknowledge the representatives of the Crown who have come today and who will attend throughout this hearing, and I particularly greet all of those of you members of the public who are watching, listening. It is important that all the citizens of Aotearoa New Zealand hear these stories, understand the pain and help us search for solutions. Warm greetings to you all. I acknowledge today the presence of the members of our Survivor Advisory Group, known as SAGE, who will be addressing us later.

My name is Coral Shaw, I am the Chair of the Royal Commission into Abuse in Care. For those who cannot see me, I have white, chin-length short hair and I wear glasses.

The Royal Commission is, and has been for several years now, been investigating the abuse and the neglect of thousands of children, young people and vulnerable adults while they were in the care of the State and in the care of faith-based institutions, or indeed in the care of both, since the 1950s. Since 2019 we have held 117 days of public hearings, that's over 13 hearing times, and mostly during that time focusing on the voices of survivors to give them the best opportunity to share their accounts of what they experienced while in care. Over those hearings they have told us, very movingly, very painfully, how they were taken into care, what happened to them while they were in care, the lasting impacts of the abuse that they suffered and continue to suffer, and importantly, their hopes for future generations.

I have to say that these accounts have been deeply moving, deeply disturbing. It is time now for Aotearoa New Zealand to hear from the organisations who were responsible for their care. We are holding two hearings to listen to and examine the institutional responses of those organisations.

Later this year in October we will be hearing from the leaders of faith institutions at our second institutional response public hearing. But it's worth knowing that while these two, the State and the faith-based, have been separated, the issues overlap and we expect that there will be references to faith-based care during this State hearing and similarly references to the State's obligations during the faith-based hearing. But today, starting today, the Royal Commission begins hearing from State agencies.

When children, tamariki, tamaiti, young people go into care, the State becomes their legal guardian. Over the next two weeks the Royal Commission will listen to the responses of government agencies, their chief executives and their other management, other executives and we'll listen to what they have to say about what survivors and others have told us. It's critical that we find out what went wrong in the past, why it went wrong, and what continues to go wrong to ensure that it does not keep happening.

So starting today, agencies will be questioned on whether their obligations were met to Te Tiriti o Waitangi, we will hear how systems were monitored for neglect and abuse, including psychological, sexual, physical and racial discrimination as well as how complaints from survivors were handled. You will hear much more of this from our Counsel Assisting the Commission, but for the meantime, that is a brief introduction from me. Nō reira, tēnei te mihi ki a koutou katoa, tēnā koutou, tēnā koutou, tēnā rā tātou katoa.

I would now like to introduce my fellow Commissioners who will be sitting listening through this week. I will start with my colleague, Dr Andrew Erueti.

**COMMISSIONER ERUETI:** Tēnā koutou, kei te mihi ki te moana e hora nei, ko te Waitematā e karapoti ana i te Motutapu me te Rangi i toto ai te ihu. Ka whakaaro atu i a rātou kua mene ki te po, e ngā mate haere moe mai rā, moe mai rā. Ko tātou anō ngā waihotanga o tātou kia ora ana tātou te kanohi ora. Ngāti Whātua ki Ōrākei te mana, te wehi, te ihi, tēnā koutou me ngā manaakitanga. E ngā ringa raupā ō koutou, ō mātou, ō tātou me ki, tēnā koutou me ngā mahi i ngā rangi nei. E mihi ana ki a koutou ngā purapura ora, koutou i whakauru mai, koutou e mātakitaki mai ana, tēnā koutou, tēnā koutou. E te kaikarakia tēnā koe, kawea nei i te taha wairua.

Ko Anaru Erueti tōku ingoa, ko Taranaki te maunga, ko Ngā Ruahinerangi te iwi, nau mai haere mai, tēnā koutou katoa. (Greetings, I acknowledge the ocean before us the Waitematā which envelopes Motutapu and Rangitoto (The day the nose bled). I think of those who have passed on, [may they] sleep well. And to us here as the living faces, my greetings. Ngāti Whātua, I acknowledge your authority, power and command. To all of you who have worked tirelessly I salute you and acknowledge the effort put in for today. To you the survivors, who are participating, and also watching, I greet you. Thank you for administering the karakia and fulfilling our spiritual ritual. I am Anaru Erueti from Taranaki, Ngā Ruahinerangi is my tribe. Welcome one and all).

I'm Anaru, one of the Commissioners, I'm a middle aged Māori man with greying hair and black speckles wearing a suit. Tēnā koutou katoa.

**CHAIR:** Kia ora. Ali'imuamua Sandra Alofivae.

**COMMISSIONER ALOFIVAE:** I le ava ma le faaaloalo lava ou te faatalofa atu i le pa‘ia ma le mamalu o le aofia, i le pa‘ia o le matagaluega, aemaise le pa‘ia lasilasi ua auai ai i lenei aso, fa‘apea i latou na afaina i ni sauaga le lelei a o aumau ai i le nofoaga, i se tausiga e le i lelei lona fa‘atinoina. (With all due respect I extend a welcome to our distinguished guests, the ministry, and everyone who is here today, the victims who experienced abuse).

Good morning everybody, my name is Ali'imuamua Sandra Alofivae and for those who can't see me, I am of Samoan and Chinese descent. Anaru would probably like to put me in his category of middle age but I refuse to look that age. So what I want to say is today is a very important day, it's a big two weeks and we are listening. Mālie lava.

**CHAIR:** Talofa Sandra. Paul Gibson.

**COMMISSIONER GIBSON:** Ko Taranaki te maunga, ko Te Rere o Kapuni te awa, ko Kaponga te tūrangawaewae, ko Paul Gibson ahau. (From Taranaki mountain, Te Rere o Kapuni river, and Koponga as my standing place, I am Paul Gibson). I am a middle-aged Pākehā male, greying and I generally sit here with one headphone over one ear listening to a

computer, checking notes on that. I'm legally blind, partially blind and I welcome the innovation of describing people as I've gone through much of my professional life not being able to identify in particular who from the audience has some lived experience of disability and the wisdom that comes with that, and also who does not have a disability and a cultural humility which you could bring with that as well, so I welcome this innovation, kia ora.

**CHAIR:** Thank you Paul, and finally Julia Steenson.

**COMMISSIONER STEENSON:** Tēnā koutou katoa. Ko Ngāti Whātua rāua ko Tainui ōku iwi. E tīmata ana ahau ki tōku Tuperiri, nā Tuperiri ka puta ko Whakaariki, nā Whakaariki ka puta ko Uruamo, nā Uruamo, ka puta ko Apehama, nā Apehama ka puta ko Poata, nā Poata ka puta ko Te Ata, nā Te Ata ka puta ko Arthur, nā Arthur ka puta ko Nelda, nā Nelda ka puta ko au. Ko Julia Steenson tōku ingoa. (Greetings to you all. I come from the Ngāti Whātua and Tainui tribes. I begin with my ancestor Tuperiri. From Tuperiri comes Whakaariki, then comes Uruamo, then Aprehama to Poata and then Te Ata, from te Ata comes Arthur, Arthur then Nelda and from Nelda to me. I am Julia Steenson).

I am one of the Māori Commissioners, I am, for those who can't see me, I am female, Māori, brown hair with brown features and I call on my ancestors this morning because to recognise the importance of this hearing, as our Chair has said in particular the disproportionate number of Māori, but for all of our survivors as well to hear from the State. Nō reira, tēnei te mihi, tēnei te mihi, tēnei te mihi ki a koutou katoa. (With that I extend my greetings to each and every one of you).

**CHAIR:** Kia ora tātou. I'll now call on counsel to announce their appearances.

**MS BEATON:** Commissioners, Kerryn Beaton as counsel assisting, I appear with a team who I will introduce a little later.

**CHAIR:** Kia ora Ms Beaton.

**MS SCHMIDT-McCLEAVE:** Tēnā koutou Kaikōmihana, ko Ms Schmidt McCleave tōku ingoa, ko mātou kei ko Mr Clarke Parker, ko Ms White ngā rōia mō te Karauna, tēnā koutou. (Greetings to you Commissioners. My name is Ms Schmidt McCleave, Myself, Mr Clarke Parker and Ms White are the lawyers for the Crown, thank you.).

**CHAIR:** Kia ora koutou. Ms Heine, sorry.

**MS HEINE:** Tēnā koutou, ko Victoria Heine ahau. Victoria Heine appearing today for the Office of Children's Commissioner.

**CHAIR:** Sorry, I missed you out as an elder of precedence, I apologies for that.

**MS HEINE:** Not at all.

**CHAIR:** Ms McKechnie.

**MS McKECHNIE:** Mōrena, ko Sally McKechnie ahau. As the Commissioners are aware I appear for Te Roopu Tautoko, for the Catholic bishops and congregational leaders. Commissioners, a small matter of housekeeping; the TRT will not be making an opening statement today, we have been granted leave to appear in the next fortnight.

However, Commissioners, as we received the evidence from the Crown on Friday and over the weekend we will not be in a position to be questioning the witnesses this week, and noting the seniority of the witnesses, it may be that they couldn't answer the questions that we necessarily had in any event. So I've been speaking to my friend, Ms Beaton. What we will do, Commissioners, is file a memoranda with the Commission in the next few days outlining the issues from TRT's perspective that we would like the Commission to explore with the Crown witness in anticipation that that will be done after the hearing.

**CHAIR:** Thank you, thank you for that advice, Ms McKechnie, and thank you for your appearance.

**MS McKECHNIE:** Thank you ma'am. And I would seek leave following the openings to withdraw for the rest of the hearings to withdraw.

**CHAIR:** Yes, that's granted, thank you. And Mr Stone.

**MR STONE:** E te tēpu, te Kaiwhakawā tēnā koutou, te whare nei tēnā tātou, te koroua nāna i huakina kei runga i te tika me te pono, tēnā koe, anei te mihi o Mātene Pōhatu, Ngāi Tāmanuhiri, Rongowhakāta, Te Aitanga a Māhaki, Kahungunu. Ki a koe, Ngāti Whātua tēnā koutou, tēnā tātou te whare. (I greet the panel and Judge, all present in this room, and to the elder for opened today righteously and faithfully. I, Mātene Pōhatu from Ngāi Tāmanuhiri, Rongowhakāta, Te Aitanga a Māhaki and Kahungunu extend my acknowledgements. Ngāti Whātua, I salute you and all here in attendance).

I appear for the New Zealand State Abuse Survivors Charitable Trust as well as certain old boys from Hato Paora College. Mōrena.

**CHAIR:** Tēnā koe, Mr Stone. I now invite Ms Beaton to open on behalf of the Counsel Assist on behalf of the Commission, thank you.

## OPENING STATEMENT BY THE ROYAL COMMISSION

**MS BEATON:** Tena koutou, tēnā koutou, tēnā tātou katoa. Ko Kerryn Beaton tāku ingoa. I appear today as counsel assisting the Royal Commission and for those who cannot see me, I admit to being a middle-aged Pākehā woman also. Today I am wearing a green jacket and I have long brown hair.

I begin also by acknowledging Ngāti Whātua as mana whenua, the survivors of abuse and neglect, including those who have passed and their whānau. Tēnei te mihi ki a koutou. I acknowledge members of the Royal Commission Survivor Advisory Group, our core participants and those who are granted leave to appear, all of the many people who have and who continue to contribute to and to support the Inquiry's work. Ngā mihi nui ki a koe.

This opening statement will outline the intended purpose of the Inquiry's hearings into institutional responses to abuse in care, and the agencies we will hear from over the next two weeks and the big questions that the Commission seeks to address.

So the purpose of these hearings. The inquiry has the broadest terms of reference of any Royal Commission of Inquiry ever held in this country. Over the last three and a half years the Inquiry has heard from thousands of people in many different ways, through private sessions, public hearings, roundtables, wānanga, hui and fono through witness statements and written accounts. During its investigations and its research work and policy work, the Inquiry has used its powers under the Inquiries Act to require people and organisations to provide us with now over a million documents containing information relevant to answering its terms of reference. And this work goes on and the Inquiry is due to deliver its final report to Government by 30 June 2023.

As noted by our chair, this is the Inquiry's 13th public hearing and its overall purpose is to publicly examine the responses of institutions to abuse in care. It was initially intended that this would be the Inquiry's final hearing and would include witnesses and evidence from both State and faith-based institutions. However, a few weeks ago a decision was made to split the hearing into two and to extend the total hearing days. This was to enable time, further time to prepare for and to hear from the faith-based institution. So a second institutional response hearing will be held in October this year for a week where witnesses from faith-based institutions will be called.

That doesn't mean, though, that failures to prevent and respond to abuse and neglect of people in faith settings will not be addressed in this hearing, as they will be. Because as is reflected in the terms of reference, the State often had and indeed has responsibility directly and indirectly for people in the care of faith-based institutions, including in schools.

Unlike most of our previous hearings, survivors of abuse will not be called as witnesses in this hearing. Instead, this hearing has a sharp focus on the State and its responses to the abuse and neglect that survivors experienced. We will pose some big

questions to Government and to the faiths in these hearings. This Inquiry has heard over and over again terrible stories of abuse and neglect of people in care in places where they were supposed to be cared for and by people and by systems that were supposed to care for them. It happened, it's still happening and it can happen again.

So it's not enough to say, "Yes, that was terrible what happened so long ago, but we shouldn't judge what happened then by today's standards." Many of the experiences of abuse and neglect that we have heard, both publicly but also privately, were common. They were common but they were never acceptable. Disconnecting people from their whānau, their whakapapa, their identity has never been acceptable.

Sexual and physical abuse and ignoring someone's complaint or cry for help if they disclose that abuse has never been acceptable. Locking people away in isolation without lawful reason has never been acceptable. Requiring disabled people to spend their lives in a room or a ward with no stimulation, no conversation, no care, that has never been acceptable. Using violence, including to administer drugs or electric shocks as punishment, has never been acceptable. Terrifying and traumatising and over-medicating people in care who cannot leave has never been acceptable. And these are only some examples of what we have heard.

The challenge for this Royal Commission and for the witnesses from the State agencies who will be giving evidence in the next two weeks, and the faiths in October, is how can the Government and the faiths in New Zealand act to address the harm that has occurred and to prevent further abuse in the future?

Kia whakatōmuri te haere whakamua -- I walk into the future with my eyes fixed on the past. This whakatauki encapsulates the Inquiry's approach to these hearings, the purpose is threefold: First, to seek acknowledgment and accountability, acknowledgment from State and faith-based institutions of the nature and extent of abuse in care, the factors which caused or contributed to it and the impacts of abuse. And accountability from those institutions for the failures to prevent and respond to abuse.

Second, to hear what lessons the institutions have learned from what happened, what changes did they make to try and prevent and respond to these failures in the past.

And third to, identify what changes are still required to address the harm that has happened and what the Government, the agencies and the faiths still need to do to ensure that the factors which allowed abuse to occur don't continue.

So over the next two weeks the Inquiry will hear from representatives of 14 agencies, the Ministry of Social Development, New Zealand Police, Ministry of Health,

Whaikaha, the new Ministry of Disabled People, the Ministry of Education, the Education Review Office, the Teaching Council, Oranga Tamariki, Department of Corrections, the Office of the Children's Commissioner, the Ombudsman New Zealand, the Ministry for Pacific Peoples, Te Puni Kokiri, and the Public Service Commission.

In total, we will hear evidence from 43 witnesses and most sessions will involve multiple people sitting in the witness box. They include the chief executives and the senior leaders of each of these agencies who will appear and answer questions, including the Chief Ombudsman, the Children's Commissioner, and the Public Service Commissioner.

In planning for this hearing it has not been possible to call evidence publicly from every State agency that was involved in providing care or involved in responding to or preventing abuse in care. However, that does not mean that those agencies have not provided information to us -- they have. All of these agencies, and many other agencies who aren't being called in this hearing, have provided written information and evidence to the Commission over the last three and a half years, and in the lead-up to this hearing, agencies were sent Notices to Produce requiring them to provide information on some key topics and the questioning at this hearing will focus on these key topics, which I'll list briefly now.

The extent to which the care system has and does ensure that obligations under Te Tiriti o Waitangi and human rights obligations are upheld.

The extent to which the care system supported or undermined the cultural continuity of Māori and Pacific Peoples and the autonomy and care needs of disabled people and people with mental health conditions.

How racism, ableism and bias has impacted the care system historically and now, for example whether it's affected the resourcing of care, or how people came to be in care in the first place.

The monitoring, oversight and safeguarding policies and practices.

The delegation of responsibility of care by the State to third parties, including faith-based institutions.

And the extent to which the State failed to meet its obligations to people in the care of these providers.

The issue of entry into care -- the circumstances in which people came to be in care and the extent to which the State attempted to implement policies to avoid pathways into care; the training, resourcing, supervision and vetting of staff and caregivers.

Failures in the provision of care including failing to provide education and healthcare and, of course, the nature and extent of abuse.

The handling of complaints of investigations and of prosecutions.

Funding and resourcing of the care system.

And lessons learned, including the extent to which recommendations from earlier reports and inquiries have or have not been implemented.

So questioning of the 14 agencies over the next two weeks will focus on many of these kaupapa or issues that I've just listed. But time will not permit us to publicly question all agencies or all witnesses on each of those. That doesn't mean that these issues will not be addressed in other ways.

The Commission has and continues to receive evidence and information in many non-public ways, including under Notices to Produce, and we continue to welcome and encourage survivors of abuse, witnesses of abuse, former staff and public servants who witnessed systemic failures to contact the Inquiry and share your experiences with us.

I want to move briefly to some housekeeping matters and then formal appearances. Each of the agencies who have witnesses appearing in this hearing have filed formal briefs of evidence. And these briefs of evidence will be available to review on the Inquiry's website along with short biographies of each of the 43 witnesses who will appear.

Each agency will have the opportunity at the beginning of their session to give additional oral evidence addressing topics they wish to highlight to the Commission. There will then be questioning from Counsel Assisting the Commission and there may be questioning from core participants and of course from Commissioners.

The hearing will be referring witnesses to documents where that is necessary but, different from our previous hearings, the documents themselves will not be live streamed. This is simply because the documents have not been redacted to protect the privacy rights of people, including survivors, and so they cannot be published. Instead, as we have always tried to do, the lawyer questioning will ensure that the relevant part of the document is read out loud into the hearing transcript.

And for similar reasons, in this hearing, the names of survivors, of perpetrators, of witnesses will usually be anonymised in questioning and in some cases the names of care places will be anonymised to protect privacy.

Finally, I confirm, Commissioners, that I appear today with a team of Counsel Assisting, who have worked across a range of our investigations. Simon Mount QC, Dr Allan Cooke, Katherine Anderson, Anne Toohey, Tania Sharkey, Michael Thomas, Ruth

Thomas, Kathy Basire, Winston McCarthy, Julia Spelman, Alice McCarthy, and Natalie Coates.

I also want to note and acknowledge the huge amount of work that has gone into the preparation of questioning for this hearing by other counsel but also by the in-house teams, ably led by Tom Powell, Belinda Himiona and Richard Roil.

Tēnā koe, Madam Chair, that's it from me. I understand we will now, I think, hear from the members of our Survivor Advisory Group.

**CHAIR:** Yes, tēnā koe, Ms Beaton. I now have great pleasure of inviting members of the Survivor Advisory Group to come forward and address the Commission.

For the record, can I note that we have Ms Tu Chapman, Keith Wiffin, Rupene Amato, Gary Williams, and they are all in the room, but we also have Frances Tagaloa and Jim Goodwin who are joining us by AVL. Tēnā koe, Ms Chapman.

## OPENING STATEMENT BY SAGE

**MS CHAPMAN:** E ngā mana, e ngā reo, e ngā karangatanga maha tēnei te mihi. Ki ngā tini mate katoa puta noa i te motu, haere, haere, haere atu rā. Hoki mai ki a tātou te kanohi ora, tēnā tātou katoa. Me mihi ka tika ki ngā purapura ora, ngā purapura whetū hoki, ko koutou, kei mua, kei tua o whakaaro. He uri tēnei o ngā kāwai whakapapa, heke iho mai i te waka o Mataatua o Tākitimu hok. Nei rā te mihi. (Greetings to the authorities, speakers, and people from the various callings in life. To the many across our country who have passed away go with our acknowledgements. Turning to acknowledge us here today I greet us as the living faces. It's also a time to acknowledge the survivors and also those who have also passed on, it is you who are at the forefront as well as in the back of our minds. I am a descendant who connects to the lines that descend from the Mataatua and Tākitimu canoes, here to acknowledge you all).

How ironic that I'm on this side of the fence. My name is Tu Chapman and alongside Keith Wiffin, Rupene Amato, Gary Williams, Jim Goodwin, Frances Tagaloa we are the Survivor Advisory Group of experts to the Royal Commission of Inquiry Into Abuse in Care.

It is also a huge honour to provide the opening mihi on behalf of SAGE, who will shortly provide their thoughts and expectations over the course of this hearing.

Lived experiences are critical to the way in which Māori share their experiences whilst in care. None more so than me. I am a ward of the State which I was made at a very young age. I suffered hugely from sexual, physical and emotional abuse by whānau members which was the reason I was placed into the care of DSW.

What was probably most impacting of all was that going into care was meant to stop the abuse, but it did not. The abuse continued by those who were tasked with my care and protection.

In preparing my kōrero today, I wanted to touch on key themes that have become evident through the life of this Inquiry. Instead, I will take the very cautious approach of trusting that the responses from institutions in this hearing will be honest and transparent.

Furthermore, I urge the Commission to be just as honest and transparent and that you appropriately acknowledge all the mātauranga that survivors have shared to help inform this Inquiry.

I wish that I did not have to be standing here today, bearing my heart and soul, because this is very hard and emotional. I could be here forever listing the impacts I have suffered, but we would need another hearing for that.

I am a survivor of abuse in State care and I have endured impact upon impact throughout my life. I would like to think that this fight has and will not be in vain. Tēnā tātou katoa.

**CHAIR:** Tēnā koe, Ms Chapman.

Mr Wiffin.

**MR WIFFIN:** Mōrena. There seems to have been a bit of a theme about grey hair this morning. I'm no different, and I think a fair few of those who have appeared in the last four years, although I do like to tell people I never went past 28.

We are having this hearing essentially because of the dreadful way agencies have conducted themselves over many decades. As Tu my colleague has said, I should not have to be standing here today. If people had actually been cared for, I wouldn't be.

That conduct has led to a monumental tragedy, which has impacted greatly on this nation and continues to do so. And as Kerryn, counsel, alluded to, it is not just an historical issue, it's contemporary.

Recently I heard an official, relatively recently, from Oranga Tamariki state that we are making improvements. And yet only to announce that abuse rates have gone up from 6% to 8. And always that data is conservative. So I stand here as much about the future as I do the past, in fact more so.

I have been intimately involved in this Inquiry in one form or another since it began. And I've been truly horrified as to what I've had to see and listen to. After I hear that at the various hearings and I eventually composed myself, the question I always ask is, how could this possibly have happened?

That is a question that all survivors deserve to hear answered. That is what I want to hear from these agencies over the course of the next two weeks. And I want to see openness, transparency, and honesty- and- answers.

Having said that, the biggest thing I hope that will come out of the next two weeks is a genuine, emphasis on the word "genuine", commitment to having a much better future and doing this much, much better in the future. And that can only be achieved one way, and that is in collaboration with survivors and that is because survivors have an intimate and profound understanding of what went so very wrong and why. They also have an understanding of how it can be done right in the future.

So I am looking for that commitment, that they will work, "they" being the officials, constructively with us.

This Inquiry, in my opinion, and the opinion of others, is the biggest of its type in the world. And that reflects the massive impact it has had on this country. Because of this tragedy, it has given rise to our gangs, it absolutely underpins our prison population and plays a substantial role in our welfare dependence. All of those things could have been avoided if people had been cared for.

I am thinking, and I will be thinking throughout the course of this Inquiry, of all those who haven't made it, including my best friend, and all those who have not yet seen justice.

And in terms of collaboration with authorities, there are still very much mixed messages coming from that quarter. In terms of MSD for example, there are still miserable and insulting offers coming from that organisation. There is still a great culture change needed.

The Oranga Tamariki Oversight Bill runs counter to everything we are trying to achieve. It does not represent effective monitoring which is why this tragedy has happened. I ask for a rethink.

Ngā mihi, and to all survivors kia kaha.

**CHAIR:** Tēnā koe, Mr Wiffin.

**MS CHAPMAN:** I'd now like to invite our SAGE members that are on Zoom, Jim Goodwin and Frances Tagaloa, kia ora kōrua.

**MS TAGALOA:** Kia ora. Can you hear me okay?

**CHAIR:** Kia ora, Frances, we can hear you well and see you well.

**MS TAGALOA:** Kia ora, Madam Chair, talofa lava. Ou te faatalofa atu i le paia ma le mamalu ua aofia i lenei aso matagofie. Malo le soifua ma le lagi e mamā. (Welcome. Greetings to

distinguished guests present on this wonderful day. Greetings to good health and wellbeing.), warm Pacific greetings, Madam Chair, and Commissioners and everyone. I'm Frances Tagaloa, a survivor of faith-based abuse. Thank you for the opportunity to give survivor comments.

I wanted to start off by saying this hearing will reveal that the State has not put survivors first, not put survivors ahead of the perpetrators and has not provided an appropriate way forward for survivors to heal and have redress.

As a survivor, I expect to hear how leaving the institutions to remedy abuse of children and vulnerable has failed and all institutions, State and faith-based, need transformative change to combat that systemic problem.

All survivors here have encountered the bureaucratic obstacles presented by systemic issues not addressed in the justice system or ACC or mental health or legal services or the statute of limitations or financial support services, or any of the Ministries.

I expect to hear how the State has struggled to have adequate Māori or Pacific consultation, representation and cultural understanding. I expect to hear explanations from the State for their appalling record-keeping and data related to abuse. And I expect to hear that the care system has just not been adequately monitored, supervised or inspected, and especially from third party care providers, and how the state has appeared also to abdicate their responsibility to keep faith-based institutions accountable.

As a survivor, I believe a public apology by the State for the horrific abuse in care is well overdue, but a real apology comes with action, with redress for survivors, financial support for survivors and creating an infrastructure that stops abuse in care, holds institutions accountable and protects our tamariki and vulnerable.

It's more important that survivors receive an appropriate personal apology and redress, not just empty words.

It's uncomfortable for me to know that while this is a State-based hearing, sadly not all institutions are here today. All the faith-based institutions should be at this hearing so that we can understand the full impact of abuse in care. And as a survivor, we expect the full force of the Inquiry to come down on the State and not hold back their relentless investigation to uncover the truth.

We do not believe that there's been significant change in State policy, processes or systems to protect our children and vulnerable, and we believe that the State institutions cannot justly monitor themselves. Survivors should not have to continue to be

re-traumatised by going back to the very institutions responsible for their abuse to seek redress.

My hope is that State institutions will stop providing excuses, defensive reasoning and justification for their mistakes and errors, but will support the initiative recommended by the Commission for a fully independent body to be developed to provide true transformative change, redress, accountability and to protect our tamariki and vulnerable. Faafetai lava mo lenei avanoa. Malo le soifua. (Thank you for this opportunity. Greetings to good health). Thank you, Madam Chair and Commissioners for the opportunity.

**CHAIR:** Talofa, Frances.

**MR GOODWIN:** Kia ora, everybody, I'm Jim Goodwin and I'm talking to you from Christchurch. My apologies for not being able to be there in person, I blame Covid.

I come from Fairlie, if you know where that is, and I'm a survivor of faith-based abuse. To describe me, I don't have much hair, I've got a moustache, I wear glasses, and I can go on the bus for free.

Now what I have to say is serious. I address myself to the representatives of the State institutions that were supposed to provide care for our people. This is not the time for well-rehearsed, smooth, bureaucratic speak. This is the time to answer the questions that you will be asked honestly and with authenticity. This is the time to deal with the abuse and the survivors of it to help them get and stay well, and this is the time to make sure that this abuse never, ever happens again.

Thank you, everybody, Rupene.

**CHAIR:** Thank you, Jim.

Tēnā koe, Rupene Amato.

**MR AMATO:** Kia ora talofa, my name is Rupene Amato, I haven't got anything prepared but my colleagues of SAGE have said quite a lot. Just to describe myself, my salt and pepper hair, I've got a budding niece who wants to be a hair dresser so the salt's a bit yellow, bit of chicken salt at the moment.

I'm a survivor from faith-based abuse. Interestingly, from last year when I gave my submission I had an outpouring of support and love from my family, the community and to a certain degree the church. It was good to see that the church actually did some stuff, but I believe they could do more. And I believe that this is where we're at at the moment today, is that the institutions can do some stuff, but we expect more, and we deserve more because we're talking for those who can't talk.

I spoke on behalf of friends who had passed away. I spoke on behalf of those who didn't want to come forward, and I stand here again to speak again for those people. And I believe that the institutions, although these conversations are difficult, with honesty comes peace. And all we're asking for is peace of mind and to ensure that -- I believe abuse is still going to occur, but we need to try and minimise it, we need to try and put steps and mechanisms in place so these institutions know that if this happens this, is the result.

And I think my colleagues have covered a lot, and so I'm just going to leave it at that, kia ora.

**CHAIR:** Kia ora, thank you. Gary Williams.

**MR WILLIAMS:** Tēnā koutou katoa, ko (inaudible) te maunga, ko (inaudible) te awa, ko Ngāti Porou te iwi. I've been involved in SAGE for the last three and a half years, I want to address the Commissioners because apparently the issues that you're looking at impact 3 or 400,000 people and I want to remind you that not many people have come forward to give their account and I want to suggest to you that that's because people don't trust the system.

So I'm going to ask you when you question multiple agencies do not allow them to give you evasive answers because survivors need to be confident that the agencies understand the issues, because without understanding the issues, they can't possibly affect what they do.

I've been thinking that the care system in our country is like a (inaudible) where people can do what they like to other people and our society as a whole doesn't really care. So we've got multiple agencies doing multiple things, there are huge gaps that need to be filled, so your job, I think, is to understand the past so that you can inform the future. Don't let the agencies pull the wool over your eyes. Thank you.

**CHAIR:** Kia ora matua. Tēnā koe.

**MS CHAPMAN:** Unless there are no further comments from the SAGE members, Frances, Gary, do you have anything further? Ka pai.

**MR WIFFIN:** I just wanted to emphasise that all survivors, whether they be faith-based or State, give the testimony to this Royal Commission on the basis that it won't happen again. That is motivation for all of them. And survivors can be forgiving. They will only give that forgiveness if there is genuine change and improvement. If that doesn't happen, every single cent that's been invested by tax payers in this Royal Commission of Inquiry will have been wasted. Thank you.

**CHAIR:** Thank you.

**MS CHAPMAN:** We'd just like to make some final acknowledgments. We'd like to acknowledge the Royal Commission of Inquiry staff, we'd like to acknowledge the Counsel Assist, we'd also like to acknowledge all of those that are involved in the background of informing and helping to assist this Inquiry.

I'd also like to acknowledge the Commissioners, tēnā koutou, it's not an easy job, I for one know that. And we look forward to having input and contribution to the final recommendations in June 2023 and we welcome that engagement with our taumata as well.

So thank you for giving us this opportunity today. Tuia ki te rangi, tuia ki te papa, tuia ki ngā muka e here nei i a tātou, tīhei mauriora. (Woven in the sky, the earth, in the fibres that fasten together mankind, alas it is life). **[Applause]**

**CHAIR:** It is now time for us to hear opening statements from our core participants and I invite Ms Schmidt-McCleave to open for the Crown.

## OPENING STATEMENT BY THE CROWN

**MS SCHMIDT-McCLEAVE:** Kei aku nui, kei aku rahi, tēnā koutou katoa. Ko te mihi tuatahi ki te mana whenua o tēnei rohe, Ngāti Whātua ki Ōrākei, tēnā koutou. Ki ngā Kaikōmihana, tēnā koutou. Ki ngā mōrehu i tū kaha, i tū maia ki te kōrero i ngā huihuinga kua pahure ake nei, kei te mihi, kei te mihi, kei te mihi. Ko Ms Schmidt-McCleave tōku ingoa. Ko mātou nei, ko Mr Clarke-Parker, ko Ms White, ngā roia mō te Karauna.

(To all who are here in attendance, greetings to you all. My first acknowledgment goes to Ngāti Whātua ki Ōrākei, the tribal authority, and also to you Commissioners, I greet you. To the survivors who stood strong and brave to share, I acknowledge and greet you all. I am Ms Schmidt-McCleave and we are Mr Clarke-Parker and Ms White, the Crown lawyers).

Good morning, everyone, my name is Rachael Schmidt-McCleave and for those who can't see me, I am a -- I own it -- a middle-aged Pākehā woman, I have brown hair and brown eyes and I'm wearing a green jacket and a green and black dress.

Thank you, Madam Chair and Commissioners, for the opportunity to present this opening statement for this critical institutional response hearing, where the Crown, as represented by the key agencies involved in State care in a range of different settings, will respond to much of the evidence it has heard over the past three years.

For those watching who may not be familiar with the Inquiry process or the Crown response, my colleague Mr Clarke-Parker and I represent all the core government agencies involved with this Inquiry. Also sitting at our table is Ms White, General Counsel for the Crown Response Unit.

The agencies giving evidence in this hearing and for whom we speak are the Ministry of Social Development, the New Zealand Police, the Ministry of Health, Whaikaha, the new Ministry of Disabled People, the Ministry of Education, the Education Review Office, Oranga Tamariki, the Department of Corrections, Te Puni Kokiri, the Ministry for Māori Development, the Ministry For Pacific Peoples, and Te Kawa Mataaho, the Public Service Commission.

One of the principles that Cabinet approved for the Crown's engagement in this Royal Commission was that the agencies should be joined up for the purposes of the Crown response. So while agencies had different responsibilities in the system over time, when I refer to "the Crown" in this hearing, that reference is to all those agencies.

I want to acknowledge the evidence the Crown has listened to, heard and absorbed over the past three years. I also want to mihi to the courage and the strength of the survivors and their whānau and supporters who have come to this very public forum to share their experiences. Your voices throughout this Inquiry are the very heart of the Commission's work. Without you, it could not succeed. And the Crown thanks you for your bravery in coming forward and speaking up.

The Crown also acknowledges survivors who have passed away but whose experiences of abuse in care will nevertheless inform the Commission's work. Understanding the past is key to ensuring it is not repeated. You have made this possible and provided a valuable service for those in care now and into the future.

During this Inquiry we have heard of many different types of abuse and neglect in a range of settings, including social welfare, educational, law enforcement, and health and disability settings.

We have heard of horrific physical and sexual abuse, of over-medication and inappropriate use of seclusion, and of families who were discouraged from visiting their loved ones.

We have heard of children being separated from their siblings, taken far from their families without being told where they were going, not seeing their parents for years, of being placed with abusive caregivers whose abuse was not checked or prevented and who were never held to account.

We heard that children, disabled people, Deaf people, people with mental conditions lacked effective ways of reporting their abuse and were not adequately monitored while in care. Further, we heard that staff and carers were not always properly trained or screened before employment.

We have heard of people who left State care with little education and limited skills to establish an adult life or a career, of children and disabled people who worked without adequate pay. We heard about a lack of support for young people to transition into adult lives after they left State care settings. We have heard of violence, lack of love, disconnection from culture and whakapapa, and generally a lack of the kind of care which all tamariki, rangatahi and vulnerable adults should have received.

We have also heard of the long-term impacts to survivors of their time in care, including physical and psychological trauma, cultural disconnection and lack of trust, including of the State and of other authority figures, which continues to impact on their lives today. We heard that these impacts are often intergenerational. Whānau members have spoken of their painful experiences of living with loved ones damaged by their experiences.

We have heard remarkable stories of resilience, but we have also heard devastating stories of loneliness, struggle, suffering and despair. We have heard, we have listened, and we have believed.

Over the past three years the Crown has also provided a significant volume of material to the Commission, as well as evidence for its various hearings and investigations.

In this opening statement, I will outline the evidence that Crown agencies who have been called to provide witnesses will give. Over the next two weeks, 11 chief executives with support from accompanying officials will respond to what they have heard.

It is important to also acknowledge that actions speak louder than words, and the Crown is acutely aware that its words over the next fortnight will be assessed through future actions and their effect over time.

It is hoped that the chief executives' willingness to appear at this hearing will be interpreted as a sign of their intent and of the seriousness with which they view the experience related by survivors.

Before I do that, however, I want to make a number of acknowledgments on behalf of the Crown. These are that, the State did not always ensure children, disabled people, Deaf people and those with mental health conditions were safe when in State care.

Second, children, disabled people, Deaf people, and those with mental health conditions experienced abuse in a range of settings controlled by the State.

Third, the State did not always stop abuse in State care when it was disclosed or reported.

Fourth, Māori, Pacific, disabled people and Deaf people were particularly negatively impacted, either by being over-represented in the services, or through the services not meeting their distinct needs.

And fifth, record-keeping issues such as gaps in recording and the loss of some records have meant that the number of children, and particularly the number of Māori and Pacific children, in State care during the period in question is unlikely to ever be known.

Individual agency witnesses will apply these acknowledgments to their own settings as relevant in the course of their evidence over the next two weeks.

I want to say that these acknowledgments and others that witnesses may make over the course of the hearing do not take the place of a more formal Government apology of the kind that the Royal Commission recommended at Recommendation 10 of its report He Purapura Ora, he Māra Tipu from redress to Puretumu Torowhānui in December 2021. The Government has instructed officials to work on what that more formal apology could look like. Final decisions on that apology are likely to be made after the Royal Commission has delivered its final report in June 2023, so that all the final findings and recommendations can be considered.

I in no way wish to denigrate the work of those good and dedicated professionals who worked in the State care system across a range of settings across the decades to provide care for children and vulnerable adults according to the standards of the day. However, society has changed since 1950 and social settings have evolved significantly. Undoubtedly there is still learning to be done and we are only part way along the path in this regard.

The way the State cares for tamariki and rangatahi, Deaf people, disabled people and people with mental health conditions has changed over time, as has the understanding of how to meet the needs of those groups. We all know more about the needs of tamariki and rangatahi as they grow and develop. We all have a greater understanding of and reduced stigma around mental illness and we all have greater acceptance of the rights of disabled people and Deaf people to live and flourish in society in the same way as others.

The Crown is party to international instruments such as the United Nations conventions on the rights of the child, the rights of disabled people, and the rights of indigenous people. Obligations inherent in those mechanisms create a context for policy making and service development that didn't exist in the past.

Our understanding of the role of Te Tiriti o Waitangi in the constitution and society of Aotearoa New Zealand and the place of Māori as tangata whenua is at a level

unparalleled in earlier decades, although there is of course still more learning and more work to do.

But 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. Throughout the period the Commission is considering, the State had an obligation to keep all those in its care safe. Through the course of the Commission's work, survivors have shared many experiences that are unacceptable and are abhorrent by any objective standard both then and now.

This bleak history has now, through this Commission, been exposed and we have all assumed the mantle of helping improve the system across all settings. The Crown hopes that this means the stories we have borne witness to will not happen in Aotearoa again. The Crown has stated repeatedly in these hearings that it is listening and that survivors are heard and they are believed.

The steps now being taken across the Crown which you will hear about in the next two weeks have been informed by the weight of the evidence, both survivor and technical evidence before this Commission. The changes made by the Crown to date have not and cannot address all the lessons learned by the Crown, but the Crown is committed to ongoing change and improvement, particularly as a result of this Commission's recommendations.

To assist the Royal Commission with its work, the Crown has provided extensive written and documentary evidence from all of the agencies to help us all understand the structural, systemic and practical factors that caused or contributed to the abuse of individuals in State care.

In this hearing those key Crown agencies will provide evidence to the Commission on many of the lessons they have learned, both over the decades and through the course of this Inquiry. They will inform the Commission about some of what has changed over the last 70 years and why. These changes include shifts in policies and professional practices such as deinstitutionalisation, community service provision, new understandings about the treatment of mental illnesses and support for disabled people, restorative justice processes, increased mechanisms for monitoring and oversight of the system, new ways of supporting families and of working more closely with Māori organisations and whānau, hapū and iwi, that are either in place or being formulated, and of working to ensure that the experiences we have heard and which have filled us all with such sorrow don't happen in Aotearoa again.

I want to emphasise that the Crown's evidence is not to suggest that the current system is perfect or that abuse never happens, but to say that while the system is much improved, there is still work to do. However, this evidence is intended to assist the Commissioners to focus your recommendations on where further improvements can be made and what else needs to be done to ensure that the experiences heard in this Inquiry aren't repeated.

Understanding the role of the Public Service is critical to understanding the evidence you are to hear. The Public Service is part of the Crown, but departments and agencies cannot act unilaterally of Government, except where independence is specifically provided for in statute.

We have the Public Service Act 2020 now where the Public Service supports constitutional and democratic government and enables the current and successive governments to develop and implement their policies, and that's set out at section 11 of that Act.

At section 14 of that Act the role of the Public Service in relation to Te Tiriti is to support the Crown as the Treaty partner in its relationships with Māori, and it does that by developing and maintaining the capability of the Public Service to engage with Māori and to understand Māori perspectives and in specific matters relating to employment of public servants.

So the Public Service is not a treaty partner in its own right but it supports the Crown as a whole in this role.

In that context then, the specific themes that between them the Crown witnesses will be addressing, and I've set them out at paragraph 35 of my opening statement, my friend Ms Beaton QC has referred to them so I don't propose to take the Commissioners through them, but they are set out there.

The witnesses you will hear from have knowledge of particular areas that will be addressed by the Commission. However, Commissioners will appreciate that these witnesses will have some limitations as to the extent of their knowledge about historical matters dating back to the earlier decades of the inquiry, and more generally, due to both the sheer volume of material relevant to the Commission's work as well as the time constraints associated with this hearing.

So I'd like to turn now to the specific Crown witnesses who will speak to the themes I have mentioned. Today you will hear from the Ministry of Social Development. Debbie Power, the Chief Executive, will give evidence, accompanied by Barry Fisk, who will give

evidence on the accreditation process, and Arran Jones, the Executive Director of Te Mana Whakamaru Tamariki Motuhake, the Independent Children's Monitor, and he will speak to the function of that monitor.

Tomorrow, Police Commissioner Andrew Coster will give evidence accompanied by Deputy Commissioner Tania Kura.

On Wednesday, the Ministry of Health and Whaikaha (incorporating the Office For Disability Issues) will appear. Specifically you will hear from the Director-General of Health, Dr Diana Sarfati and she'll be accompanied by Dr John Crawshaw, the Director of Mental Health and Addiction, acting Associate Director-General Mental Health and Addiction, Dr Arran Culver, and Deputy Director-General Māori Health, John Whaanga.

From Whaikaha, the Acting Chief Executive Geraldine Woods will give evidence. She will be accompanied by Amanda Bleckman, the Interim Deputy Chief Executive, Service Delivery, who will speak on operational settings and safeguarding, and Hannah Kerr, General Manager, Policy who will speak to Whaikaha's policy and strategic direction. And specifically Whaikaha's evidence will speak on the reasons that Whaikaha was established and its strategic direction in supporting disabled people, tāngata whaikaha Māori, Pacific disabled people and whānau, the Enabling Good Lives approach and the disability system transformation, and how Whaikaha seeks to uphold Te Tiriti o Waitangi and tino rangatiratanga and safeguard disabled people from abuse and neglect.

On Thursday the 18th the Ministry of Education will appear. The Secretary and Chief Executive, Iona Holsted, will appear, accompanied by David Wales, National Director Learning Support; Rachael Vink, Manager National Service Support and Guidance; Hira Gage, Director Tai Tokerau (Ops); and Tipene Chrisp, GM Policy (Māori education).

Finally this week, you will hear from the Chief Executive of the Education Review Office, Nicholas Pole, accompanied by his DCE of Evaluation and Review and Māori, Linda Pura Watson, and Jane Lee, DCE, Review and Improvement.

That will be followed by Lesley Hoskin the Chief Executive of the Teaching Council, the regulatory body for teachers.

Next week on Monday the 22nd, three days of evidence from Oranga Tamariki will commence. Chappie Te Kani, the Chief Executive will appear, accompanied by the Chief Social Worker, Peter Whitcombe, Nicolette Dickson, the Tumu Tuarua Te Kounga o te Mahi me ngā Wheako Deputy Chief Executive, Quality Practice and Experiences, Paula Attrill, General Manager, International Case Work and Adoptions, Frana Chase, Director,

Youth Justice Transformation, Aiolupotea Sina Aiolupotea Aiono Chief Advisor, Pacific and Claudia Boyles, Chief Advisor, Disability.

On Thursday 25 August, the Department of Corrections Chief Executive, Jeremy Lightfoot will appear, accompanied by Emma Gardner, Director Mental Health and Addictions, Neil Beales, General Manager Custodial and Chief Custodial Officer, Jessica Borg, General Manager Psychology and Programmes, and Rebecca Barson, General Manager Reintegration and Housing.

At the end of the week on the last day of the hearing, you will hear evidence from Laulu Mac Leauanae, the Chief Executive of the Ministry for Pacific Peoples, accompanied by Aiona Matthew Aileone, the Deputy Secretary, Policy. They will be followed by David Samuels, Chief Executive of Te Puni Kokiri, accompanied by Grace Smit, Deputy Secretary, Strategy, Finance and Performance.

And finally you will hear from Peter Hughes, the Public Service Commissioner.

Necessarily there will be limits on the extent to which witnesses are able to speak to the past, such as when they do not have personal knowledge of the events or if the records cannot be found. If appropriate, the Crown may file additional evidence to assist the Commission. Nonetheless, these witnesses will speak not only to the specific themes I've expressed above, but also about the lessons, the many lessons their agencies have learned along this pathway to improve the various State care systems. Nō reira, tēnā rawa atu koutou katoa.

**CHAIR:** Kia ora, thank you for your opening address. Are there other counsel who wish to address? Ms Heine.

**OPENING STATEMENT BY OFFICE OF THE CHILDREN'S COMMISSIONER**

**MS HEINE:** Madam Chair, Commissioners. I will explain for those who can't see me, I have, with some help from my hairdresser, brown blonde shoulder-length hair, blue eyes and today I'm wearing a cream jacket with shiny buttons.

It's my pleasure to present some brief opening statements on behalf of the Office of Children's Commissioner today. The OCC welcomes the opportunity to engage with this Commission. As the Commissioners will know but others in the room may not, the Office of Children's Commissioner is an independent Crown entity, it has its own legislation, and that means that it is not subject to ministerial direction.

It has a range of statutory functions, broadly relating to investigation, complaints, monitoring and advocacy for those under the age of 18. As is clear, the State care and

protection system has failed to serve the interests of mokopuna, significant changes are necessary.

The OCC has and will continue to advocate for mokopuna, to ensure that their voices are heard as well of those of their whānau and that those voices are valued, acted upon, so as to finally address, prevent and eliminate abuse of mokopuna in care.

And whilst acknowledging the past, the OCC wishes to use the opportunity to give oral evidence next week to provide the Commission with future focused recommendations for systemic change, such recommendations being centred around and drawn from the voices of thousands of mokopuna who have spoken to the OCC over many years.

Next week, the Commission will hear from three witnesses, Her Honour Judge Frances Eivers, who is the current Children's Commissioner. She's held that position since November 2021 and follows in a long lineage of distinguished Children's Commissioners. Ms Fiona Cassidy, who is the current Executive Director of the OCC and has held that position since March 2022. She will principally address the Commission on the funding challenges which are a key part of the evidence that you will hear from the OCC. And finally, Ms Glenis Philip-Barbara who was appointed as the first Assistant Commissioner Māori in November 2020. She finished her tenure as ACM in July 2022 and she will appear next week under summons.

Those witnesses will, if required and to the extent that they can speak to the past, but inevitably their ability to do so is circumscribed by the length of time that they've worked for the office and the length of time that they've been in their particular roles. So in anticipation of this problem, the Section 20 response which the OCC filed, we've endeavoured to make that as comprehensive as we can, and that draws on discussions with past staff and past Commissioners. So I'm hoping that that will be a useful repository of historical material.

Subject to any direction from the Commission as to specific areas of interest, there are four key themes that the OCC witnesses wish to speak to. The first of those is funding. The OCC has never been adequately funded to carry out its wide-ranging statutory duties and functions fully and effectively. This has meant that over the 33 years of its existence, adequate and effective oversight of State care of mokopuna has been limited.

The OCC has shared its frustrations about inadequate funding with the Government, but increased funding has not been forthcoming and there is background to those requests in the Section 20 response.

While OCC believes that it has achieved considerable success with the limited funding available, much more needs to be done and can be done with adequate resourcing. And I note that the present funding structure also sees the OCC as an independent Crown entity reliant on funding being sought on its behalf from other agencies. So instead of being able to make its own bid for funding in the yearly budget cycle, it goes through other agencies. It has no -- as I understand it, it has no direct voice.

The second key theme is independence. As stated by both the OCC and many across the children's rights sector, the State cannot monitor itself. That is a non-sequitur. On multiple occasions, the OCC has called for the necessity of an adequately funded entity that is independent from government to carry out monitoring functions. Regrettably, present government policy has gone in the other direction, with the Oversight Bill currently before the house. The proposals in that bill are a long way away from the independent oversight that mokopuna in care need and deserve, and even further from a future where by Māori for Māori approaches are embedded.

A third key theme, complaints. A functional mokopuna- and whānau-centred complaints system has never existed and is urgently needed. The OCC has repeatedly highlighted its concerns with the current complaints system, including access to complaints mechanisms, remedy and redress. An effective complaints system must be mokopuna- and whānau-centred, it must be accessible, it must be independent, it must respond to mokopuna within their timeframes, and it must be subject to robust oversight.

Fourthly, by way of themes, Māori. The current system does not have Te Tiriti at its foundation. As we know and we've heard again today, there is significant overrepresentation of mokopuna Māori among those experiencing poor outcomes in poverty statistics, care systems and Youth Justice. The long-term implications and costs of that are not only for those individuals personally, but for society as a whole, as we heard from the representatives of SAGE this morning, there are wider issues here beyond simply the impact on individuals.

In particular, there is a disproportionate number of mokopuna Māori in State care and one of the papers in the bundle that will be put to the witnesses next week talks about I believe the prison -- that once a person gets into State care they get on a trajectory, which never ends particularly well.

The OCC has long held concerns about the way the Care and Protection system is failing Māori, and has called for by Māori for Māori approaches across the system. And Ms Philip-Barbara talks or will talk next week a little bit about how in her view some of

those changes could be implemented, building on what we're starting to see in other areas within the State sector.

So these key themes feed into the OCC's six future-focused recommendations for systems change and they're set out in the Section 20 response. Those are that Te Tiriti must be the foundation; by Māori for Māori approaches must be prioritised; appropriate training, guidance and support is critical for all adults involved in delivering care for mokopuna in the State system; mokopuna and whānau voices must be listened to; a functional complaints system has never existed and is urgently needed; and a well-resourced and truly independent monitor is needed.

The OCC is grateful for the opportunity to provide a written response to the Commission and to give oral evidence next week. This process has allowed the office to reflect on it practice and journey over the last 33 years, including identifying the barriers faced, the successes achieved, and the continued need for evolution and improvement to better serve our most vulnerable.

The OCC hopes that the Commission will benefit from its evidence and draw on the insights and recommendations provided. It further hopes that when the recommendations eventually made by the Commission are produced they will lead to transformational and sustainable change so that those failed by the system are no longer required to repeat their stories again and again and again. And we have heard in very powerful terms from SAGE representatives this morning just how hard that is.

So those are the opening remarks on behalf of the OCC. I haven't filed a written statement, but can do so if that would be of assistance to the Commission. I can file that later in the week.

**CHAIR:** Only if you wish -- it has been very competently transcribed, so unless you particularly want to I think we can take the transcription as your record.

**MS HEINE:** Thank you, ma'am. Finally, I will be here next Thursday the 25th with my clients. With respect, could I seek leave to be excused until that time, Your Honour?

**CHAIR:** Yes, of course, thank you very much. Thank you for your submission.

Mr Stone, do you wish to make any opening remarks?

## OPENING STATEMENT BY NEW ZEALAND STATE ABUSE SURVIVORS CHARITABLE TRUST

**MR STONE:** Thank you, ma'am. In terms of a description of how I look, Mr McCarthy whispered in my ear: You know, if you were to get the latest Muscle and Fitness magazine,

put a suit on him and black hair -- did I hear you right? It was something along those lines, ma'am.

**CHAIR:** There are some parts of the evidence which we can't believe, but I won't comment on that any further, Mr Stone.

**MR STONE:** Ma'am, I was listening to the opening statements from my learned friends, I adopt everything they've said, everything they've said. And it got me thinking about my own clients. And when I stood here about a year ago I made reference to the work that I had done in respect of those Māori Battalion soldiers who never got their medals and I thought about that and when MSD are coming here later today, and they'll probably think what an earth does that kaupapa have to do with them being here today? And I thought to myself, it has everything to do with today. Because those men wouldn't come forward to claim their medals because the process was wrong. The process was wrong because there's a principle and the principle that we call tikanga is kanohi ki te kanohi, face-to-face.

The policy then, and it is still the policy today, is that medals were sent in the mail and their position was kāo, you need to do this properly. I have clients who will not embark upon the MSD compensation process because that process is wrong.

GRO-B lives in a bus to Aotea Harbour, Aotea Harbour is between Kawhia and Raglan. He suffers from diabetes, he's an amputee, he's a survivor of State abuse. He knows that he could come forward and make a compensation claim. And I said to him, "Why don't you?" He said to me, "David, the reason why I don't come forward is because I need to keep what little mana I have left." Just like those soldiers who wouldn't come forward because the process was wrong, their process is wrong.

The Army, they are calling, as I said before, the process to give these medals project whakatika, to make right. The question that needs to be asked to MSD is, how are they going to make it right? How are they going to give mana to GRO-B and the many other people who refuse to come forward because their process is not right?

That's all I need to say.

**CHAIR:** Tēnā koe. Are there any further submissions by way of opening? Then that brings the opening part of our proceedings to a close, Ms Beaton, unless there's anything else you would like to say?

**MS BEATON:** No, thank you, Madam Chair, I think we take the morning break now.

**CHAIR:** We're actually on time, which is remarkable.

**MS BEATON:** We are on time but we have scheduled the evidence from the Ministry of Social Development to start in the afternoon. I'm just over the break going to have a talk to my friends from the Crown Response Unit about whether we can bring that forward a little.

**CHAIR:** Yes, if we can I think it's a good idea to give plenty of time for these witnesses to give their evidence and for questions to be asked. I only ask that as soon as we know when the matter is going to start that we advise the public, because they will be anxiously waiting to watch and it's important that they know that it will be starting early, so just by way of a warning, there's a strong possibility that the evidence of the first witness, Ms Power, will be starting before 2.15; is that correct?

**MS BEATON:** Correct, yes, but we will notify of course the public in the room but also via the livestream.

**CHAIR:** Thank you. Can I just acknowledge all of the opening submissions from SAGE, SAGE members, from the Crown, the Office of the Children's Commissioner, from Mr Stone on behalf of his clients, tēnei te mihi ki a koutou katoa. We will take the morning adjournment.

**Adjournment from 11.27 am to 1.52 pm**

**CHAIR:** Good afternoon, everybody, and welcome back to our first session of witnesses at this hearing.

Ms Toohey.

**MS TOOHEY:** Good afternoon. Ko Anne Toohey tōku ingoa. I am one of the counsel. For those who cannot see me, I am a middle-aged Pākehā woman with naturally blonde hair and I'm wearing a cream jacket with a black check through it. I'm one of the Counsel Assisting the Commissioners as the Commissioners are aware.

With us this afternoon we have the witnesses for the Ministry of Social Development and there will be some evidence-in-chief so I will invite my learned friend Ms Schmidt-McCleave.

**CHAIR:** I'll do that when I've affirmed the witnesses. Good afternoon to each of you and welcome to the Royal Commission. I'm just going to give you one statement and I'll ask if you will agree with it.

**MINISTRY OF SOCIAL DEVELPOMENT**

**DEBBIE POWER, BARRY FISK AND ARRAN JONES (Affirmed)**

**QUESTIONING BY MS SCHMIDT-McCLEAVE:** Tēnā koutou ano. I'd like to introduce the Commissioners to our three witnesses and then what I propose to do is have the Chief Executive, Ms Power, has a written statement she would like to read out and then I'm

hoping in the time available Mr Fisk and Mr Jones will also have very brief statements that they would like to give to the Commission.

So at this end of the table, Commissioners, we have Debbie Ann Power, the Chief Executive of the Ministry of Social Development; next to Debbie we have Mr Barry Fisk, the General Manager of Te Kāhui Kahu at the Ministry of Social Development; and at the end, Mr Arran Jones, the Executive Director of the Independent Children's Monitor. Tēnā koutou katoa.

Tēnā koe, Ms Power. Your full name is Debbie Ann Power?

**MS POWER: [Nods]**.

**MS SCHMIDT-McCLEAVE:** And you're the -- I'll just remind you to say "yes" or "no" for the stenographer.

**MS POWER:** Yes.

**MS SCHMIDT-McCLEAVE:** Thank you. And you're the Chief Executive of the Ministry of Social Development.

**MS POWER:** Yes.

**MS SCHMIDT-McCLEAVE:** And you were appointed to this role in February 2019 for a term of five years.

**MS POWER:** Yes.

**MS SCHMIDT-McCLEAVE:** Now, the Commissioners have received your written brief of evidence and have a copy of that.

What Ms Power intends to do is speak to that but in a slightly reordered fashion and what we can do following this hearing is provide a copy of what Ms Power's going to give to the Commissioners so you can match it to her written brief.

So I will hand over to you, Ms Power, to read out your statement.

**MS POWER:** Thanks, Rachael.

**CHAIR:** And if I could just remind you, if you haven't already, to be slow, for your signers and our transcriber.

**MS POWER:** Tēnā koutou. Ka mihi ki te mana whenua, e ngā mana nui o te Kōmihana Karauna e tau nei. E ngā mōrehu o tēnei kaupapa tēnā koutou katoa. Ko Debbie Power tēnei e mihi ana, nō Te Tai Tokerau ahau, tēnā koutou, tēnā koutou, tēnā koutou katoa.

I am the Chief Executive of the Ministry of Social Development, I was appointed to this role in February 2019 for a term of five years.

Prior to becoming the Chief Executive of the Ministry, I held a position of the Statutory Deputy State Services Commissioner and Chief Executive at the State Services

Commission between August '15 and February 2019. In this role I was accountable for supporting the Commissioner with Chief Executive appointments and performance management.

I started my career, my Public Service career in 1980 as a frontline case manager at the then Department of Social Welfare. I've held a range of senior roles in the Ministry, including Deputy Chief Executive Service Delivery between 2012 and 2015, Deputy Chief Executive Office of the Chief Executive, 2010 to 2012, and Regional Commissioner for the Northland region 2001 to 2005.

In these earlier roles I oversaw a range of significant projects, including the implementation of welfare reform and the movement of social housing needs assessment from Housing New Zealand to the Ministry.

I hold an Executive Master's in Public Administration from Victoria University of Wellington.

To begin, I wish to make some overarching comments. Understanding the role of the Public Service is critical to understanding the evidence you are to hear. Public Service is part of the Crown, but departments and agencies cannot act unilaterally of Government, except where independence is specifically provided for in statute.

Under the Public Service Act 2020, the Public Service supports constitutional and democratic government and enables the current and successive governments to develop and implement their policies.

Under the Act, the role of the Public Service in relation to the Treaty is to support the Crown in its relationships with Māori under Te Tiriti o Waitangi by developing and maintaining the capability of the Public Service to engage with Māori, and to understand Māori perspectives in specific matters relating to employment of public servants.

The Public Service is not a treaty partner in its own right, but supports the Crown as a whole in this role.

On behalf of the Ministry, I wish to acknowledge the numerous accounts given by survivors of immense suffering and tremendous courage in the face of adversity. The Ministry has listened carefully to survivors' evidence and I would like to recognise the bravery and courage of survivors in providing their evidence to this Commission.

Although the role in the care system that the Ministry performs today is in relation to the particular functions I will explain, the Ministry remains committed to continually improving that work to better support the care system operated by Oranga Tamariki. This is reflected by the monitor and the accreditation processes in place.

I want to specifically acknowledge the evidence provided by survivors about their experience of redress. Although I understand that it is not within scope of this hearing and therefore not in the scope of my evidence, the evidence has been heard and I acknowledge that the Ministry's redress system has not always got things right for claimants.

This was covered in detail at the Commission's State Redress Hearing, and evidence was provided by my colleagues, Simon MacPherson as to the establishment and history of the Ministry's redress system for responding to historic claims of abuse, Linda Hrstich-Meyer as to how the Ministry has responded to and assessed historic claims including current processes, and Garth Young as to the range of issues and practices relating to the historic claims process.

The Ministry is committed to the cross-agency work taking place to support the Crown response to the Royal Commission's redress report He Purapura Ora, he Mâra Tipu and to improve redress for survivors.

I want to reiterate and support the acknowledgments set out on behalf of the Crown in the opening statement provided by Crown counsel today. In addition, I have considered the acknowledgments specifically put to the Ministry by the Commission and would like to respond to those.

I acknowledge that it is not within the scope of our current historic claims process to take into account a person's loss of culture or cultural disconnect while in State care. As was discussed in detail at the State Redress Hearing, MSD's claims process was developed in response to litigation and required us to apply a legal framework to claims. However, no matter what the legal position is, what is clear from the evidence we have heard through the work of the Commission is that loss of culture for survivors is hugely significant.

Cultural considerations haven't formed an integral part of the way in which we've gone about the historic claims redress processes over the years. We will consider as part of the Crown engaging on this question how these key aspects will need to be a part of the new redress process.

I recognise that across the board disabled people, Deaf people, and people with mental health conditions face additional barriers to access many services. I acknowledge that more needs to be done in this area. While the MSD redress system can be accessed in a number of ways in writing, by e-mail, with advocates through representation, it has not gone far enough. For example, not all of our documents are in an accessible format. I understand the importance of accessibility and it is a focus for the cross-agency work on any redress system.

I am responsible for the strategic oversight of the Ministry whose role and functions are: Funding for community service providers, employment support, income support including payments, entitlements and New Zealand superannuation, social housing assessments and services, access to concessions and discounts for senior citizens, families and low income New Zealanders, student allowances and student loans, information, knowledge and support for families and communities, campaigns that change antisocial attitudes and behaviour, and services to uphold the integrity of the welfare system and minimise the debt levels of the people we work with.

The Ministry also has functions outside of its core business, including Te Kâhui Kahu historic claims and the Independent Children's Monitor.

To supplement the evidence I give, the following witnesses will be appearing on behalf of the Ministry to address issues of accreditation and the monitor: Barry Fisk, the General Manager of Te Kâhui Kahu and Arran Jones the Executive Director of the Independent Children's Monitor.

With the establishment of Oranga Tamariki Ministry for Children in 2017, and the resulting transfer of Child, Youth and Family functions from the Ministry to Oranga Tamariki, the Ministry has several relatively confined areas in which it engages with or relates to people who were or are in State and in the care of the State: Managing claims of abuse or neglect for people who were in the care, custody or guardianship of the Child Welfare Division, the Department of Social Welfare, or Child, Youth and Family, the historic claims process, and these matters were subject of the Ministry's evidence at the Commission's State Redress Hearing; providing social services accreditation on behalf of the Ministry For Pacific People, the Ministry of Housing and Urban Development, Ministry of Justice, Department of Corrections, Ministry of Social Development, and Oranga Tamariki; hosting the monitor within the Ministry on an interim basis. After the Oversight Bill is passed, the monitor will sit as an independent unit within the Education Review Office; working with other agencies in the wider social sector to support government priorities and improve the well-being of New Zealanders.

Oranga Tamariki was established on 1 April 2017 and took on the responsibilities and functions of the previous organisations that held its present day function. As the Ministry is no longer involved with the delivery of the care system and does not provide care services, Oranga Tamariki will be giving evidence to the Commission about the care system.

**MS SCHMIDT-McCLEAVE:** And if I could just jump in there, Ms Power, and note for the Commissioners that Mr Fisk has given a full brief of evidence on accreditation. He does wish at the end of Ms Power's evidence just to make a couple of short paragraph statements, so Ms Power, if you could keep reading from 5.2. Thank you.

**MS POWER:** Accreditation provides assurance that organisations can safely deliver social services to their community. It is like a warrant of fitness check for social service providers. Being accredited shows that an organisation has strong and safe business practices.

Changes to the system of accreditation have occurred because the Ministry's role and function of accreditation has increased since 2015. The Ministry's current accreditation function has evolved from approving and accrediting third party providers on behalf of the Ministry and Oranga Tamariki to accrediting on behalf of six agencies: Ministry For Pacific Peoples, Ministry of Housing and Urban Development, Ministry of Justice, Department of Corrections, Social Development and Oranga Tamariki.

The Ministry's accreditation process for assessing the suitability of third party providers is run by Te Kâhui Kahu. While Te Kâhui Kahu is an independent government business unit which was established in August 2021, it is hosted by the Ministry, which means that the Ministry provides Te Kâhui Kahu with corporate services such as IT systems, human resources, payroll and property.

Te Kâhui Kahu assesses third party providers against specified accreditation standards within its accreditation framework. There are processes in place for accreditation to be removed by Te Kâhui Kahu and ways for Te Kâhui Kahu to respond where issues or concerns about an organisation's accreditation are raised.

**MS SCHMIDT-McCLEAVE:** Again, if I can just stop you there to note that Mr Jones has also given a full brief and he talks about the position prior to 2019. So Ms Power, if you could just start reading again from 6.3 and complete your final comments. Thank you.

**MS POWER:** The subsequent 2017 review of the independent oversight arrangements for the Oranga Tamariki system and children's issues recommended the need for greater oversight of New Zealand's child protection system, specifically: System level advocacy for all New Zealand children and young people; oversight and investigation of complaints of matters related to the application of the Oranga Tamariki Act 1989 and/or children in the care or custody of the State; and independent monitoring and assurance of the operations and obligation delivered under the Oranga Tamariki Act 1989 and associated regulations.

In response, Cabinet agreed that the Ministry be appointed the independent monitor from 1 July 2019 to establish the monitoring function with the then in principle agreement that it be transferred to the Office of the Children's Commissioner once a robust monitoring function is established and a new legislative framework is in place. This was then superseded by a Cabinet agreement on 10 May 2021 that the monitor would be established as a departmental agency within ERO.

The monitor operates independently from the Ministry's core business. The Ministry's role is to design and establish the framework for the independent monitoring of compliance within the National Care Standards Regulations, information that is disclosed on abuse or neglect in State care, and how Oranga Tamariki is responding, specifically, National Care Standard Regulation 69 and 85. And establish the broader monitoring frameworks and conduct full monitoring for a period from December 2020 to refine the operation of the function before it is transferred.

The Government agreed to a phased approach to implementing the necessary changes to develop and establish the monitoring function. The current monitoring arrangements are set under the existing legislative framework, under the Oranga Tamariki Act 1989. Future arrangements are relying on the passing of the Oversight Bill.

Once the Oversight Bill is passed, the monitor will be hosted by ERO. I understand that the monitor will remain operationally independent, led by statutory officer who will also be its Chief Executive.

As the Chief Executive of the Ministry, I wish to again acknowledge the experiences shared by survivors of abuse throughout the Commission's inquiry. The opportunity for the Ministry to hear direct from those who have suffered such harm is significant and I am committed to learning from their experiences as well as from the work of the Commission.

The Commission has provided a pivotal opportunity for all Crown agencies, including MSD, to reflect on our role in the lives of tamariki, rangatahi, and their whānau. The Ministry's overarching purpose is to help New Zealanders to be safe, strong and independent and I am committed to ensuring that the Ministry achieves this purpose in the work we undertake. Thank you.

**MS SCHMIDT-McCLEAVE:** Ngā mihi ki a koe, Ms Power. I just will spend a couple of moments with Mr Fisk and Mr Jones. So turning to you, Mr Fisk, tēnā koe. Your full name is Barry John Fisk.

**MR FISK:** Barry John Fisk, that's correct.

**MS SCHMIDT-McCLEAVE:** And you're the General Manager of Te Kâhui Kahu?

**MR FISK:** I am.

**MS SCHMIDT-McCLEAVE:** And the Commissioners have a copy of your full written brief, so we don't need to go through that in detail, but if you have it in front of you, could you just read your paragraphs at part 2 of that brief.

**MR FISK:** The Ministry wishes to make overarching comments about the accreditation system.

I would like to begin by acknowledging the work of the Royal Commission and in particular the survivors who have come forward to share their experience.

It's a privilege to lead a unit that can provide an independent assessment of the suitability of providers to deliver safe, quality services. New Zealanders have a reasonable expectation that when they access services funded by the Government that these services have met standards that give them confidence to use them.

The assessments we complete can cover the breadth of the social sector where a provider or a legal entity who holds multiple contracts for different across multiple agencies attains on accreditation. This provides transparency for the government and communities and it place the organisation Te Kâhui Kahu in a unique position of having a whole-of-system view across the sector.

The process of accreditation is completed on a regular review cycle based on risk. This means that at the time an organisation is accredited it is judged to be fit for purpose and appropriate for the service it offers. It does not mean that accreditation monitors the quality and performance of services. This is the responsibility of the ministries or departments who contract for those services.

It is my hope that our work continues to refine, modernise and introduce Te Ao Māori in our approach to accreditation will lead to improved outcomes for all whānau and families, individuals, community, especially Māori.

**MS SCHMIDT-McCLEAVE:** Thank you, Mr Fisk, and Commissioners. At part 3 Mr Fisk sets out the scope of his evidence, and if the Commissioners are happy to take the remainder of his brief as read.

**CHAIR:** Yes, certainly.

**MS SCHMIDT-McCLEAVE:** Thank you.

Mr Jones, if we could just turn now to your evidence and again, the Commissioners do have a copy of your written brief. But your full name is Arran Scott Jones?

**MR JONES:** That's correct.

**MS SCHMIDT-McCLEAVE:** You're the Executive Director of the Independent Children's Monitor.

**MR JONES:** Also correct.

**MS SCHMIDT-McCLEAVE:** If you also could read out for the Commission your position statement at part 2.

**MR JONES:** Tēnā koutou katoa. Ko wai au? Nō Te Papaioea ahau, kei Whanganui a Tara ahau e noho ana. Ko Arran Jones tōku ingoa, he Tumu Whakarae Ahau ki te Mana Whakamaru Tamariki Motuhake. Before addressing, as described, I'll just make my opening statements. I'd like to begin by acknowledging the work of this Commission and in particular those who have come forward to share their experiences.

When tamariki and rangatahi are removed from whānau and brought into care, it must only be out of the utmost necessity. It must only be to improve their lives and always with a view to their eventual return home, and it is heart-breaking when this is not the case.

Personally, it is a privilege to lead the establishment of the monitor and make a contribution to the improvement of the quality of care, and in time the Oranga Tamariki system more generally.

Sustained monitoring, increased transparency and the sharing of insights will influence change. Highlighting good practice will show others what can be done. Transparency over areas that demand improvement will help direct effort. Sustained and consistent monitoring will drive accountability.

It is my hope that the monitor's work in partnership with the Children's Commissioner and the Ombudsman will improve the experience of care so that tamariki and rangatahi can feel safe, be safe and have every opportunity to live their best lives.

It's important to note that the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill, the Oversight Bill, is currently before Parliament, and in developing the functions of the monitor will provide, through the Bill, oversight of the whole of the Oranga Tamariki system. It will also provide for greater advocacy for all children and young people in New Zealand and also a creation of a new Children and Young People's Commission.

The Oversight Bill is currently through its second reading and I look forward to its passing so that we can continue with our journey. Ngā mihi.

**MS SCHMIDT-McCLEAVE:** Thank you, Mr Jones, and you've addressed the Bill in more detail in your written statement so if Commissioners are happy for that also to be taken as read?

**CHAIR:** Yes, thank you.

**MS SCHMIDT-McCLEAVE:** Ngā mihi ki a koutou, if you can just remain there for questions from my friends Ms Toohey and Mr McCarthy and Dr Cooke and then the Commissioners, thank you.

**CHAIR:** Thank you.

Ms Toohey.

**QUESTIONING BY MS TOOHEY:** Tēnā koe, Ms Power. I just want to start with some snapshots of the scale of abuse that the Ministry received through the Historic Claims Unit. I'm going to take you through what is by no means a complete picture of some spreadsheets from information that the Ministry has provided to the Commission.

If we could start with MSD 0015420. This is a summary, Ms Power, of abuse claims made to the Ministry relating to some key residences that the Commission has drawn out from the responses. And I'm just going to ask you some questions about this so that we can get a sense of the scale of allegations that were made to the Ministry.

Just looking at the first line there, the residence Kohitere, that is recording that 228 complainants came forward to the Ministry with a total of 812 allegations of abuse, 550 being physical, 134 sexual, and 102 emotional. Do you see that there in the first line?

**MS POWER: [Nods]**.

**MS TOOHEY:** We can see similarly for the next two lines in relation to Epuni and Hokio the numbers of complainants' abuse allegations and the type of abuse that was perpetrated.

And do you agree with me, Ms Power, that these are very high numbers of allegations of abuse within these residences?

**MS POWER:** Yes, I would.

**MS TOOHEY:** And perhaps if we scroll down the page to Whakapakari, are you familiar with that provider of care as a third party provider to the State, accredited by the Ministry under 396 of the Oranga Tamariki Act, and you can see there that 40 complainants came forward with 176 allegations of abuse, 99 physical and 21 sexual, 42 emotional, to the Ministry; and similarly, Moerangi Treks, another third party 396 provider, eight complainants with 49 abuse allegations, 30 physical and four sexual.

And if we go back and look at the entire page, there is no provider on this page of care with less than two allegations of sexual abuse?

**MS POWER: [Nods]**.

**MS TOOHEY:** Thank you. I just want to go now --

**CHAIR:** Just make sure that you voice your response, please, so that we can get it recorded.

**MS POWER:** Yes.

**MS TOOHEY:** I just want to go now please to a different spreadsheet which is MSC 0008283. And these are, again, screenshots that have been prepared by Commission staff from information provided to the Ministry to the Commission. And the first -- these have been filtered per person who's alleged to be a perpetrator of abuse, and do you see the first named person, that's number 1 at the top, the first person named, and then at the bottom of that page in the corner we have 48 of 442 records, and that's indicating, Ms Power, that there were 48 allegations of abuse against that first person named.

I just want to take you through the first line first, demonstrating physical abuse, you can see there the period is 1949 at Ōwairaka, the next line is sexual abuse in the same year, and then if we scroll down these entries all relating to the first person named, you can see they all relate to Ōwairaka Boys' Home, and if we go to the end we get to 1988.

So this information, Ms Power, I think you'll agree, reflects that there were allegations made to the Historic Claims Unit against this one person committing a range of the types of abuse, physical, sexual, and emotional, for a period spanning 1949 to 1988, 39 years. Do you agree with that?

**MS POWER:** Yes.

**MS TOOHEY:** And do you agree with me, Ms Power, as a general proposition that that one example of that first person named in the spreadsheet demonstrates why we need a very robust system of monitoring and oversight of State care?

**MS POWER:** Yes.

**MS TOOHEY:** I want to take you now to page 14, I'm not going to go through each of these perpetrators of abuse, but if we go to page 14, a person named at number 9. So on the next page we can see at the bottom left of that table again the number of allegations, so 25 allegations against this person. And once again, if we just undertake a similar exercise starting at the top at line 14 there, the first allegation is 1968, at Epuni, of a sexual nature, and then as we scroll down we see allegations of, once again, sexual, physical and emotional abuse spanning all the way through until 1978, a ten-year period.

And you would have familiarised yourself, I imagine, with this spreadsheet prior to the hearing, Ms Power. Do you agree with me that across a range of institutions, there are individuals who are alleged by survivors to have committed abuse over quite lengthy time periods across a range of institutions nationally throughout New Zealand?

**MS POWER:** That's what the spreadsheet indicates, yes.

**MS TOOHEY:** And that's what the Historic Claims Unit heard from survivors of abuse?

**MS POWER:** Yes.

**MS TOOHEY:** I just want to go now to third party providers, so to MSC 0008284. This is a, again, this third party service provider that we alluded to earlier of Moerangi Treks and Eastland Youth Rescue. So if we see there in the bottom left there are 49 allegations in relation to this provider, and if we start at the top they range from 1993, if we just see that date, but remaining on that page, if we look at line 2795, you can see there a person, who I will refer to as Person B, is alleged to have committed physical abuse from 1997, and that same person, Person B on the next page, features quite heavily throughout 1997 in terms of an alleged perpetrator of abuse; do you see that?

**MS POWER:** Yes.

**MS TOOHEY:** Then we come to Eastland Youth Rescue Trust, a separate organisation, and Mr McCarthy will be asking questions in relation to this, but do you see there that there are -- first of all, there are 42 allegations, as we can see, of abuse in that third party provider and then if we go back to the main document, we can see that at the top line and throughout that page that same Person B is alleged to have committed abuse at Eastland from 1998, and that continues down to 1999.

Do you agree with me that, once again, this demonstrates the need for oversight, the fact that one person is alleged to have committed abuse in one organisation that is contracted to the State, and then a second?

**MS POWER:** Yes.

**MS TOOHEY:** The last spreadsheet I want to refer you to is MSC 0008286 and you'll see there that this relates to Whakapakari, another third party provider. And if you look at the bottom corner again, you'll see there are 176 allegations of abuse in relation to Whakapakari and if we have a look at the top line, 1988, are you familiar with the person, the first person named there as the person who ran this care provider?

**MS POWER:** Yes.

**MS TOOHEY:** And that person's name features frequently throughout this document, do you agree, right through to the very end of the document in 2003?

**MS POWER:** Yes.

**MS TOOHEY:** And once again, this third party provider is continuing to provide services to the State from 1988, at least on these documents, through to 2003?

**MS POWER:** Yes.

**MS TOOHEY:** Thank you.

I now want to move to a different subject, Ms Power, and that relates to what the Ministry did as a result of hearing about claims of abuse against current staff of Child, Youth and Family and now Oranga Tamariki.

So if I understood your evidence correctly, Child, Youth and Family were within the Ministry of Social Development until 2017; is that right?

**MS POWER:** That's correct.

**MS TOOHEY:** There's one particular individual that I want to ask you about who I will refer to as Person A. And if we could bring up document ORT 011834.

So if we have a look at this document, it says at the top "Employment Historic Claims" and it's got "Allegations against current staff". If we go down to, I think, page 3, the first entry on that page, the person I'm referring to as Person A. My understanding from this document is that Person A was named to the Ministry of Social Development as someone who was known to be a perpetrator of abuse by Cooper Legal. Is that your understanding?

**MS POWER:** That's my understanding.

**MS TOOHEY:** And that he was -- the allegations are summarised in this table as being physically abusive and it's listed there that this person would beat up boys when they were doing physical training, would kick, punch and clothesline boys, set up fights between boys, and so on, that's listed there.

My understanding from the evidence that the Commissioners received earlier from Garth Young is that after the Ministry got this general information from Cooper Legal, they made attempts to deal with it by getting further information and also involving the Police, but that for various reasons, they couldn't take it any further at that time.

Have I summarised that fairly?

**MS POWER:** Yes, I think so, yeah.

**MS TOOHEY:** After that, did the Ministry then receive, rather than from Cooper Legal, from actual claimants to the Historic Claims Unit, claims in relation to physical abuse by Person A?

**MS POWER:** Yes.

**MS TOOHEY:** If we just bring up the spreadsheet in relation to that, which is MSD 0015421, and we can see that this relates to Person A as per the top of the spreadsheet, and at the bottom left we can see there are 26 allegations of abuse. My understanding from information provided to the Commission is that two of those allegations in relation to sexual abuse

could be discounted by the Ministry as having been capable of having been occurred for various reasons; is that right?

**MS POWER:** Yes, I understand that's true.

**MS TOOHEY:** And that leaves 24 allegations. And then in that column that says "Did allegations meet criteria", you can see some say yes, and there's one there on that page that says no, can you just explain what that refers to?

**MS POWER:** That relates to the criteria as it relates to historic claims process. So people make a claim, we have a look at it and we accept it for the purposes of historic claims that that behaviour happened.

**MS TOOHEY:** My understanding also from evidence given by Ms Hrstich-Meyer to the Commission earlier, is that sometimes claims were looked into in some more detail by the Ministry and sometimes they were accepted to actually have happened. And certainly in one of the documents provided to the Commission it appears that the Ministry accepted a claim that one, at least one claimant was physically abused by Person A.

Do you agree, having reviewed the documentation prior to today, that that's what occurred?

**MS POWER:** Yes, all I would add is in the context of accepting a historic claim, not in relation to a finding of fact as it relates to employment matters, that's the distinction.

**MS TOOHEY:** Yes, in that document it also refers to the Ministry having accepted claims of physical abuse by Person A against three other claimants. So four claimants the Ministry accepted physical abuse occurred for the purpose of settlement, and there were a total of 14 claimants to the Ministry in relation to Person A and my understanding is a total of 18 claimants were paid compensation in relation to some form of abuse by Person A; is that right?

**MS POWER:** I'm not aware of that number, I'm sorry, I'd have to come back to you, but I accept the earlier premise.

**MS TOOHEY:** The information provided to the Commission, actually that was updated at 1.55 pm today, is that Person A, after the 2006 information we looked at earlier that showed that Person A was a current staff member then, that this person was re-employed on 1 July 2009 and was transferred to a different Youth Justice facility on 8 June 2015, employment checks were done in 2009 and that person remains employed now at a Youth Justice facility.

When did the Ministry of Social Development act on these allegations of physical abuse in relation to Person A as a current employee?

**MS POWER:** In relation to the first comment that you've made about the updated information, I'm not aware of that information, so I'm sorry about that, I can't respond to that. What I can say is that we did make referrals in relation to Person A to Oranga Tamariki, some general information in 2019 and then in 2020, 2021 more specific referrals.

**MS TOOHEY:** What about earlier, Ms Power, when Person A was an employee of Child, Youth and Family within MSD, what was the process then in relation to receiving on the one hand through the Historic Claims Unit allegations of physical violence by that person and in another part of the Ministry, that person is providing care directly to young people? What did you do when he was an employee of Child, Youth and Family within the Ministry about that? What was the process undertaken?

**MS POWER:** So as I understand the process is when -- at that time period we would have had a historic claims process and we would have had -- Child, Youth and Family would have been part of MSD. So in order to refer information over, clearly there was a time period where we could not get the information that we needed and it went on far too long before anything was resolved.

So again, we went back to Cooper Legal to say was there more information, but in relation to how we deal with allegations of abuse for current staff members, we have two processes, one if the claimant is prepared to go to Police we can go to Police, otherwise then we do a referral. Now, in this case it clearly didn't happen until 2019, which was way too late.

**MS TOOHEY:** Would the Ministry accept that this represents a major failing in relation to safeguarding children in care?

**MS POWER:** I think what I would say is in the current environment now we would be looking at different, well, we wouldn't -- I guess what I would say is we didn't do our best work at that time in relation to dealing with that particular complaint, and that is hugely unfortunate.

**MS TOOHEY:** I think you'll be aware that the Historic Claims Unit actually interviewed Person A in 2013 in relation to some of the allegations. Were you aware of that?

**MS POWER:** I'm not aware -- I'm aware that some interviews were done; sorry, I'm not clear that that was specifically in relation to Person A.

**MS TOOHEY:** Mmm.

**CHAIR:** Could I ask a question of clarification, when you say "referral", what do you mean? You were saying complaints are received, the complainant didn't want to refer but you did refer, to whom did you refer?

**MS POWER:** I guess what I'm saying is, when an allegation is made, if a complainant wishes to go to the Police then they could go to the Police. Otherwise we would do an assessment in relation to if the person is currently employed, what their role is, and talk to Oranga Tamariki in relation to if they are currently still employed.

**CHAIR:** So the referral is to Oranga Tamariki?

**MS POWER:** Yes.

**CHAIR:** Is it a referral or just a -- what do you mean by a referral?

**MS POWER:** We would notify them that concerns were raised in relation to an existing staff member.

**CHAIR:** Right, okay. And basically hand over to them for investigation or who then held responsibility for looking into that?

**MS POWER:** I'm unsure about that in relation to the past, I can only talk about it in the current. So in the current, we would hand that responsibility over to Oranga Tamariki and it would be their responsibility to work through the resulting process, because it becomes then an employment matter, and the relationship in terms of the employment matter is between the person and their employer.

**CHAIR:** Doesn't it become an abuse matter?

**MS POWER:** I guess it depends -- I guess there are two tests, one is in relation to the test in relation to historic claims, and the other test is in relation to the relationship, the employment relationship between the staff member and the organisation who is their employer.

**CHAIR:** Those two are linked though, aren't they?

**MS POWER:** They are linked but they're not necessarily the same test or one needs to uphold one process for the other process, if that makes sense.

**CHAIR:** Are you saying one test trumps the other test? No? I'm just trying to work out what the -- what is prevailing here, is the protection of the child prevailing or is it the protection of the employment status that's prevailing?

**MS POWER:** I think it's complicated, to be honest. So you have -- absolutely we would want the protection of the child to be at the centre. All I'm simply saying is we also have an employment process that we must go through, and if people -- if allegations are made against current staff members, their employer is required to put those allegations to them and go through a process. Now, that doesn't mean to say we don't care or want to protect the child who is at the centre of that, I'm not saying that at all. Absolutely they're both

absolutely important, I'm just saying, they're different -- they have to go through different processes. And I'm talking about historical claims versus current, right?

So you absolutely have to protect the child, that is absolutely first and foremost, I want to make very clear about that. But there's still a process that has to go through that you have to put an allegation to an existing staff member and that relationship and employment relationship is between the employer and the person.

**CHAIR:** So what are the steps, granting all of that, what are the steps in the meantime while that employment process is taking place, what steps are taken to preserve, as you quite rightly say, the most paramount consideration and that's the protection of the child?

**MS POWER:** I think it would depend upon what the allegation was, I think it would depend about -- depend on what processes were put in place, but I mean you would, in the first instance, remove the -- potentially remove the person from the location or the role. But again, this is all hypothetical.

**CHAIR:** Yeah, sure.

**MS POWER:** But you would make sure that the child had all the supports that they needed, that they were clear that, you know, this was not their fault, that we put in whatever processes around the child, and their whānau, to make sure that they were safe. At the same time, we would make a judgment or the employer would make a judgment about the severity of the allegation and making sure that that separation happened in order to make sure that the child was safe, absolutely you would do that. That's a given.

**CHAIR:** And that's your current practice?

**MS POWER:** I'm saying that's what would hypothetically happen if that happened, yes.

**CHAIR:** Thank you for clarifying that.

**MS TOOHEY:** Ms Power, I'm sorry about putting you on the spot with that additional information, I only got it just before lunch.

**MS POWER:** Yes, that's all right.

**MS TOOHEY:** There is one further question I think that the Commission could benefit from some clarity on, which is when Person A was an employee of Child, Youth and Family, and the Ministry was getting an historic claim, so that wouldn't involve a referral through to a different organisation because it's the same Chief Executive, isn't it, the same organisation?

**MS POWER:** At that time, yes.

**MS TOOHEY:** So I've been through the case studies that were provided on Friday by the Ministry of Social Development in relation to these claimants, and they date back to assessments in 2015, one was 2013. So these are times when Person A is employed within

the Ministry of Social Development. So can you explain why nothing was done by the Ministry in relation to one of its staff who is alleged to have committed so much physical violence against children in care?

**MS POWER:** I can't answer that question based on what I've seen. What I can say is clearly it took too long for us to get to a resolution to be able to progress it.

**MS TOOHEY:** I just want to move on to a different topic now, Ms Power, and that's just to explore a little bit more about the Beattie Report that you referred to in your evidence, which we can bring up on the screen, MSC 0008447. And my understanding from the report generally is that it was essentially commissioned by the Ministry in order to identify ways in which independent oversight of Oranga Tamariki could be strengthened after that organisation was set up in 2017; is that right?

**MS POWER:** That's correct.

**MS TOOHEY:** If we can go to -- I think it's page 21, paragraph 1. If you see the second paragraph there, which begins "To that end", and it talks there about, so this is in the Beattie Report, the recommendation was "consideration to one Commission", and there had been reference to the Office of the Children's Commission, so one Office of the Children's Commission with two full-time statutory commissioners, a Children's Commissioner and a Commissioner Care and Protection with separate roles and statutory responsibility. And both roles would be publicly notified, etc.

I just had a question for you, Ms Power, which you might be able to answer given your background with the Public Service Commission in particular. The Office of the Children's Commissioner, that's an Independent Crown Entity, isn't it?

**MS POWER:** That's right.

**MS TOOHEY:** Can you explain how that differs from a government department?

**MS POWER:** An Independent Crown Entity or an ICE as it is commonly referred to, is independent, which means it has the ability to advocate or provide commentary, so it's not -- it's independent of Government policy, if that makes sense, yeah.

**MS TOOHEY:** Right. And we heard this morning from the lawyer for the Office of the Children's Commissioner that funding for an Independent Crown Entity is difficult because they can't petition the Government separately for funding, that that has to come from other Government agencies. Do you know anything about that?

**MS POWER:** I think that Independent Crown Entities have a direct relationship, or the commissioners or the chairs or whatever role they are, have a direct relationship with

ministers, so are entirely within their, you know, ability to talk to ministers about whether or not they feel they have sufficient resources.

Of course in this case the Ministry of Social Development is also the monitor for the Children's Commissioner, so we can have a role to advise as well, but there's nothing stopping a commissioner or the head of an Independent Crown Entity talking to the responsible minister about their level of resources or funding.

**MS TOOHEY:** Does the Ministry of Social Development seek funding for the Office of the Children's Commissioner in its vote from Parliament or not?

**MS POWER:** We do. We can -- that's exactly our role because the funding -- because of our role as the monitor, yes.

**MS TOOHEY:** If we just go to the bottom of that page -- sorry, just up above the earlier part, the page above. And here we have the comment at the final paragraph, if I can call that out, that: "The importance of the quality of systematic monitoring can't be understated, it must provide credible evidence-based assessments, be a respected source of independent advice and add value to Oranga Tamariki as well as contributing to a learning system of improvement in practice, service and delivery." And then on the next page: "It must also be a trusted source of independent reporting that provides assurance to Ministers, Parliament and the public".

Do you agree with me that that's a central theme throughout this report, is the need for independence and independent monitoring?

**MS POWER:** Yes.

**MS TOOHEY:** The recommendation in the report to have monitoring undertaken by a separate commissioner is different to the arrangement, isn't it, with the Independent Children's Monitor that's actually transpired?

**MS POWER:** That's right. And I think Ms Beattie was clear in her report that she was making a recommendation but that further analysis or acceptance by ministers was still the next steps.

**MS TOOHEY:** Yes, yes. I just want to ask you some questions, though, practically about how the Independent Children's Monitor works, though, and its level of independence. You mention in your evidence that it's an independent Government business unit. What exactly does that mean?

**MS POWER:** I might just pass to Arran Jones at this point, if it pleases you, just to talk about that aspect of it.

**MS TOOHEY:** Thank you.

**MR JONES:** Yeah, look, I think there's two parts to this. The first is how we operate currently within the Ministry of Social Development, and then the second part is what is proposed in the Oversight Bill in the future for the monitor.

In terms of the first, Debbie's already discussed or mentioned the independence of us within the Ministry of Social Development, we consider ourselves to be, although part of MSD, we are effectively see ourselves as adjacent to them, and we have a great deal of operational autonomy in terms of how we operate.

Then in terms of the reports that we've already published, those reports go direct to the Minister for Children. The first time he sees those reports is in their final form, and then those reports go to the agencies that have statutory care responsibilities for children so they can reply, and then we publish those reports on to our website.

So that is the current operation of the monitor.

**MS TOOHEY:** As public servants though, do you agree with me that there are limitations on the amount of public criticism that can be levelled by public servants? The Independent Children's Monitor staff are public servants, are they not?

**MR JONES:** That's correct.

**MS TOOHEY:** So my understanding is that public servants can only criticise the Public Service publicly using a protected disclosure through the Protected Disclosures Act?

**MR JONES:** Yeah, I'm not quite -- in terms of the function of the monitor, you're thinking about, I think, a specific set of circumstances, if something was to arise and we were to become privy to it, as opposed to our general practice of how we monitor the system; is that correct?

**MS TOOHEY:** No, I'm asking about the level of independence in terms of being able to publicly criticise the Government, in the same way that the Ombudsman or the Office of the Children's Commission would be able to. I think you'd agree with me there's not quite the same latitude for public servants.

**MR JONES:** There are a couple of things I'd point out. I think it's really important to see the role of the monitor within the oversight system, which was proposed by Sandy Beattie in her report. We are part of a system working together and so while the monitor is currently a departmental agency and that's what its proposed future is also, we also work with the Office of the Children's Commission and her role as an advocate and her freedom to do that.

We also work with the Ombudsman who has a very high independence status and their ability to complete investigations and to handle complaints.

So I think it's really important to see the whole of the oversight system working together.

The second point is, and as I mentioned, the future for the monitor. The Bill that's currently before the house has specific provisions in it to safeguard the independence and I think this speaks to the point that you're raising here, and clause 16A of that Bill sets out currently that "A minister of the Crown must not direct the monitor to stop carrying out an activity or prevent the monitor from carrying out an activity that the monitor considers necessary to enable them to perform or exercise their functions, duties or powers under this act."

This clause is very unusual, but it helps promote and protect the independence of the monitor and our ability to report fairly what we hear in communities and the data and information that we gather.

**MS TOOHEY:** If I could just go back to you, Ms Power, just in relation to the reference in the Beattie Report to the Ombudsman, the Ombudsman is different again, is an officer of the Parliament, perhaps an even greater degree of independence, would you agree, than the Office of the Children's Commissioner?

**MS POWER:** Yes.

**MS TOOHEY:** If we have a hierarchy we could see the Ombudsman is at the top in terms of independence, the Office of the Children's Commissioner under that and then public departments under that again?

**MS POWER:** I think it's the legislative framework that's also important. As Arran has already said, part of the proposal in the Oversight Bill is to ensure that the monitor can continue.

Your comment in relation to a Public Service agency criticising an individual and the scope of that, I mean, the monitor, if they found that there was an issue in relation to an individual would be talking to the employer again about that individual. I'm not sure that -- I wasn't quite sure what you were talking about when you were talking about to "criticise an individual".

So, sorry, I just didn't quite understand what you were meaning by that, because the monitor in the course of their work, if they found that there was an issue in relation to an individual, be it a current staff member, a person delivering a programme, would be talking to either the employer about that concern, or to the funder of that programme. The monitor's role is to look at the care system in its entirety.

Sorry, I just didn't quite understand.

**MS TOOHEY:** I might have used the wrong term, I was meaning to indicate that public servants cannot publicly criticise the Public Service, another Government department. Because that really is my question for you, Ms Power, in terms of oversight of, for example, MSD and Oranga Tamariki in terms of the example of Person A, who is overseeing you in terms of that particular failing that we discussed before? Where is the oversight of the Ministry?

**MS POWER:** So, well, in the current context if a Chief Executive has -- does not deal with particular issues, then there's always the employer of the Chief Executive which is the Public Service Commissioner. So ultimately our employment is subject to -- he appoints, so -- and our performance, no matter in whatever aspect, we're accountable to him.

If in failing our duty to deliver for ministers, then we have also a relationship with ministers, but it's not an employment relationship. So oversight of agencies, arguably, is with the Public Service Commissioner.

**MS TOOHEY:** Does that include the system, when it's the system that's failing between public departments? Is there oversight of that from the Public Services Commissioner?

**MS POWER:** I would argue that that is arguably in scope.

**MS TOOHEY:** Thank you.

Commissioners, I have no further questions for this witness. The proposal is for Mr McCarthy to now ask questions of Mr Fisk, if that is suitable to you.

**CHAIR:** Yes, thank you.

**MS TOOHEY:** Thank you, Ms Power.

**CHAIR:** Tēnā koe, Mr McCarthy.

**MR McCARTHY:** Tēnā koe, ma'am. Good afternoon, Mr Fisk.

**MR FISK:** Afternoon.

**QUESTIONING BY MR McCARTHY:** My name is Winston McCarthy, I'm one of the lawyers assisting the Commission. Just for audio description purposes, I am quite tall, of Māori and Samoan descent. Like many, my hair is greying and I'm wearing a charcoal suit.

Mr Fisk, did you want to provide an audio description?

**MR FISK:** Yes, I am not as tall as you but also have greying hair and I'm wearing a dark suit.

**MR McCARTHY:** When I was reading your evidence I was struck by the phrase "warrant of fitness", you're comparing the accreditation service to a warrant of fitness. Just so I'm clear in my mind, Te Kâhui Kahu is responsible for providing the initial accreditation for external agencies to be funded within the care system; is that correct?

**MR FISK:** Not just the care system but --

**MR McCARTHY:** In the broader context, but for our purposes what we're interested in --

**MR FISK:** Yeah, for this purpose the warrant of fitness as I describe it helps others understand that we are saying this organisation is fit for purpose, and I think I may have made comments in my testimony also that the service quality and the monitoring of that service delivery, those contracted services is the responsibility of the Ministry or the Department that has that contract.

**MR McCARTHY:** We'll come back to that point, but just the second aspect, like a warrant of fitness in the real world, these usually expire.

**MR FISK:** Yes, they do.

**MR McCARTHY:** And you're responsible for reaccrediting.

**MR FISK:** Every two years.

**MR McCARTHY:** You just spoke before about quality and performance, and you're responsible for warranting strong and safe business practices. At what point does quality and assurance reflect on strong and safe business practices?

**MR FISK:** It's a combination of things in my view. There's the responsibility of the organisation to act in the interests of its service recipients and consulting with them. So, for example, it's incumbent on the service provider to actually make sure that the service recipients, the child, the young person's views are taken into account, and that exists even though the responsibilities for care have now transferred, but that's the responsibility.

But equally, the running of an organisation in an appropriate fashion, so good governance, proper employment contracts, performance appraisals, complying with the rule of law are all things that make an organisation fit for purpose. If you don't have those things in place, then you will -- there will be a greater chance of service failure without those things.

**MR McCARTHY:** So you'd agree that it's important for the warranting process to be robust?

**MR FISK:** Yes.

**MR McCARTHY:** To ensure that unfit organisations aren't funded in the care system.

**MR FISK:** Correct.

**MR McCARTHY:** And you'd also agree that if an unfit organisation manages to be accredited, there could be serious consequences just like the warrant of fitness in the real world.

**MR FISK:** Correct, yes.

**MR McCARTHY:** In tab A of your evidence you outline the whakapapa or history of Te Kâhui Kahu.

**MR FISK:** Yeah.

**MR McCARTHY:** And what I propose to do today is examine the accreditation process that was active during our scope period.

**MR FISK:** Yes.

**MR McCARTHY:** So the New Zealand Community Funding Agency, during our scope period during the 1990s, they were responsible for approvals as opposed to accreditation.

**MR FISK:** Yes, that's right. And "approval" is a word used in section 396 of the Act, so that is the correct terminology.

**MR McCARTHY:** Am I correct in saying that today, Te Kâhui Kahu, while not involved in approvals, the accreditation process, if they don't pass the accreditation process, that would preclude them from being funded within the care system?

**MR FISK:** No, that's not the case today, because Oranga Tamariki is now responsible for section 396 itself, so it approves organisations for care and it contracts with those organisations for care and it ensures through the care system that quality standards are met.

**MR McCARTHY:** I'm aware that the approval function has moved.

**MR FISK:** Yes.

**MR McCARTHY:** But you describe contracts, are you saying that if you didn't accredit a third party provider, they would still be able to contract with Oranga Tamariki?

**MR FISK:** Prior to the transfer of the delegation, that might be the easiest way for me to explain, that is correct, without accreditation/approval the organisation should not be able to contract.

And if it helps, that applies to all organisations that we accredit.

**MR McCARTHY:** So the New Zealand Community Funding Agency, which was one of your predecessor organisations, they were responsible for approvals. What was the role of then Child, Youth and Family in the accreditation/monitoring process?

**MR FISK:** Well, at various stages they were together, but you could say that Child, Youth and Family, when Community Funding Agency and Child, Youth and Family were apart, there was Care and Protection and Youth Justice components to Child, Youth and Family.

**MR McCARTHY:** So we've set out the framework and now we're going to look at particular examples.

So we are going to look at Moerangi Treks. Now, Moerangi Treks was one of the settings that the Community Funding Agency approved?

**MR FISK:** That's correct.

**MR McCARTHY:** And you note in your evidence that it was approved in 1997.

**MR FISK:** Mmm-hmm.

**MR McCARTHY:** At paragraph 7.7 of your evidence --

**MR FISK:** Let me grab that -- yes, I've got that now.

**MR McCARTHY:** -- you say there that the approval process for Moerangi Treks was completed prior to allegations of any abuse being made.

**MR FISK:** That's correct.

**MR McCARTHY:** If we could bring up our first document, and that's document MSD 0002979 for the record, and if we scroll down to the first page of the -- page 4. And if we could just call out the first paragraph.

**MR FISK:** Yes, I have that.

**MR McCARTHY:** So it says there: "At various times over recent years, questions have arisen over the care of some clients placed on the Moerangi Treks programme."

So this document, I probably should have addressed it before, it's a joint report --

**MR FISK:** That's correct.

**MR McCARTHY:** -- prepared by Community Funding Agency and...

**MR FISK:** Yes.

**MR McCARTHY:** And this was completed in 1998, so this was a few months after the initial approval.

**MR FISK:** That's correct.

**MR McCARTHY:** So you'd agree that it's safe to say there were issues prior to Moerangi Treks being approved?

**MR FISK:** Indeed.

**MR McCARTHY:** One specific example of allegations being raised is contained in my next document, and that's document EXT 0015888. So as you can see, this is an internal Child and Young Person Services memorandum. Do you see the date of the document?

**MR FISK:** Yes, I do.

**MR McCARTHY:** This was two years prior to the approval, wasn't it?

**MR FISK:** Mmm-hmm.

**MR McCARTHY:** In the highlighted paragraph, I'll just call that out, it sets out here, doesn't it, that "Palmerston North CYFS received a report from South Auckland Child Youth Persons Service and that allegations were raised regarding assaults on a boy by both staff and residents on the programme." So it would appear that the accreditation process in this instance did not -- it took place in a vacuum of this information.

**MR FISK:** That would seem to be the case.

**MR McCARTHY:** And during opening statements today, Keith Wiffin, he asked two questions that he wanted us to examine, he asked how did this happen and he also asked what has been done to ameliorate things in the interim.

**MR FISK:** Sure.

**MR McCARTHY:** So I understand you weren't there at the time, we're just interpreting historical documents.

**MR FISK:** Correct.

**MR McCARTHY:** But from the evidence we have a received, it seems that there were issues in communications between different agencies.

**MR FISK:** That would be my take on it. The predecessor organisations rather largely used manual paper systems, there was no systemic ability, or there was no systemic sharing of files or information.

**MR McCARTHY:** So today, what mechanisms are in place to ensure that information that comes to Oranga Tamariki is passed through to Te Kâhui Kahu?

**MR FISK:** So there's a range of relationship meetings that take place, but perhaps the most important, the most important thing that's in place now is that we share a resource directory from which accreditation information is placed, assessments are kept, and flags of concern that Oranga Tamariki have and we have are examined before any contracting arrangements are entered into. So we have a way of sharing information now using technology that simply didn't exist in that time.

**MR McCARTHY:** Thank you for that, that answers my question. I did have one sort of further question. The operation of that system that you just described would be dependent on humans doing their jobs, that's correct, isn't it?

**MR FISK:** Yeah, as in all things.

**MR McCARTHY:** There's another question that I'll come back to as we go through the different organisations. When accrediting, first accrediting organisations to be introduced into the care system, to what degree do you examine the track record or the background of the organisation and the other contexts in which it operates?

**MR FISK:** So there's a -- today?

**MR McCARTHY:** Today.

**MR FISK:** Today there's an extremely thorough investigation, if you want to use that word, "evidence collecting" would perhaps be a better one, and this may take some time, it takes somewhere between -- it takes three months between an organisation, putting in an

application for accreditation and then it being approved and sometimes they don't get approved because there is insufficient evidence to allow us to form a view.

**MR McCARTHY:** So a proposed organisation, would it need a track record of success before being accredited?

**MR FISK:** Often times they're new organisations, so in the current set up I've got 2,000 organisations that we accredit, we probably get 350 new applications a year, so the rest of the organisations that we're talking about are re-accreditations.

**MR McCARTHY:** Okay. Now, we discussed before Moerangi Treks was approved in 1997 and allegations surfaced subsequent, quite shortly afterwards.

**MR FISK:** Indeed.

**MR McCARTHY:** We're talking four to five months.

**MR FISK:** Mmm-hmm.

**MR McCARTHY:** If we could bring up the document we looked at before, MSD 0002979 again. And we'll just stay on this page. So this is a letter that accompanied the report investigating the allegations of abuse.

**MR FISK:** Correct.

**MR McCARTHY:** Can you see the date in the left-hand corner?

**MR FISK:** Yes, I can.

**MR McCARTHY:** And on page 4 there's a couple of highlighted dates there in the third paragraph.

**MR FISK:** 28 November?

**MR McCARTHY:** Mmm-hmm, yes, and 17 December.

**MR FISK:** Yes.

**MR McCARTHY:** This background is setting out the background of the investigation that took place by the Community Funding Agency, and Child, Youth and Family. Now, if you recall, the first date was May, so it appears that there was around five months between the allegations being raised and a report being completed.

**MR FISK:** That's right.

**MR McCARTHY:** I've read your complaints policy in one of the tabs of your brief of evidence. What would your expectation be today in terms of timelines of an investigation of this sort?

**MR FISK:** My expectation, and this is my experience, my expectation is once a complaint's made, then the agencies that have an interest or contracting arrangement with that provider come together as per that complaints arrangement, a plan is developed on how to manage that, the agency, in this case if it was a care service, they would be the responsible agency

to go and do the initial investigation. If it was appropriate they would do that with the Police. Subsequent to that investigation, we would examine the output of that and then determine, we take an independent view of whether the standards that applied to that organisation had been breached.

Now, if they had been breached, then we would look to impose corrective action, required action which may lead to a suspension.

**MR McCARTHY:** So timeframe wise?

**MR FISK:** Well, it's hard for me to say, but I would have thought that this would be something that would take less than a month. Our part would be subsequent to, you know, for example the Oranga Tamariki and Police example. I have want one to bring to mind which is about a school care provider and that was dealt with by Oranga Tamariki and the Police within a week and we had dealt with our part of the investigation within ten days.

**MR McCARTHY:** Another feature of this investigation was it appeared that the children remained at Moerangi Treks while the investigation took place. Would you be involved in deciding whether children remained with allegations or would that be Oranga Tamariki?

**MR FISK:** That's the responsibility of Oranga Tamariki.

**MR McCARTHY:** So I'll put those questions to them, okay.

Could you go to page 7 of the report. So if we can scroll down a little bit. So you see there it says that there have been five incidents that have been corroborated by more than one of the clients in the programme, and do you see the named individual in the first highlighted paragraph?

**MR FISK:** Yes, I do.

**MR McCARTHY:** So that is Person B that my friend Ms Toohey spoke of before.

**MR FISK:** Yes, it is.

**MR McCARTHY:** So it says that, point 1, there was a physical assault, bashed her on the head, point 2, there was a rope around the neck, if you can scroll down to the next page, again it's Person B, these are uncorroborated, so there's only one witness to them, but again, the use of bolt cutters to assault someone, and the same Person B telling other boys to beat up another boy.

This isn't the sort of person that you'd want around children, is it?

**MR FISK:** No, but that's a question you'd need to address to social workers who would place children in those places, but my opinion is no.

**MR McCARTHY:** I guess the question I'm putting to you is, if you're aware that this person, Person B, had done these things, you wouldn't accredit the organisation that they worked for, would you?

**MR FISK:** No, if I had that knowledge, no.

**MR McCARTHY:** I think that's an important part, because what we're going to turn to next is examining Eastlands. But before we do that we're just going to go back to the first page of this document.

If you could call out the highlighted bit.

There it says as a result of the investigation, the report that we just read, the approval has been suspended.

**MR FISK:** Correct.

**MR McCARTHY:** That is on 29 May 1998.

So if we can bring up document MSD 0002986. So this is another Child, Youth and Family internal memorandum. Do you have the document in front of you?

**MR FISK:** Yeah, I'm just getting it out of my tab.

**MR McCARTHY:** If we just call out the yellow highlighted part.

So this document is dated 15 October 1998.

**MR FISK:** Mmm-hmm.

**MR McCARTHY:** So is that around five months after the report we just read?

**MR FISK:** Yes.

**MR McCARTHY:** Have you read the highlighted paragraph?

**MR FISK:** Yes.

**MR McCARTHY:** So you can see there that this new organisation called Eastlands was managed by Person B --

**MR FISK:** Indeed, yes.

**MR McCARTHY:** -- who we spoke to before, and it says also that they received a full approval from the Community Funding Agency.

**MR FISK:** Yes.

**MR McCARTHY:** So it would appear that the approval person, the responsible approver was, we're interpreting obviously, but if I had to guess, perhaps wasn't aware of what occurred in the investigation.

**MR FISK:** I would most certainly believe so.

**MR McCARTHY:** So going back to today, what processes are in place to ensure that internal silos within your organisation do not preclude the sharing of crucial information like we've just seen here?

**MR FISK:** Yeah, sure, so we go back to my description of the IT system and the two flags that allows the things to occur, but not only that, each accreditation report that we write goes to the organisation for whom we contract, because you'll be aware from my testimony that I effectively work for these agencies, so all of the reports go to the appropriate agencies for whom we are doing the accreditation on behalf of.

So both at the system level, if you like, technology level, and then the referral of the reports and the provider, I might add, gets a copy of the report too.

**MR McCARTHY:** I've been advised we're going to take a break, if that's okay.

**MR FISK:** Sure.

**MR McCARTHY:** But we'll come back and examine that.

**CHAIR:** Yes, it's 3.30 which is the time designated for tea to be drunk, so I think we'll take a break now, 15 minutes, is that the time allotted? Yes, it is, so we'll take a 15-minute break and return for your questioning again, thank you.

**Adjournment from 3.27 pm to 3.46 pm**

**CHAIR:** Just before we commence, just a word for the audience in the room, you will not be seeing the documents that are being referred to. It was explained earlier that the documents can't easily be redacted, and there are a whole lot of privacy issues arising out of other things appearing on the page, and for that reason I'm sorry that we won't be showing those either on the screen or on the livestream, but counsel will, wherever they can, read out the relevant parts that they're referring to. Thank you.

Yes.

**MR McCARTHY:** We left off discussing the approval of Eastlands and it appeared to be almost like a Phoenix organisation, would you agree with that sort of characterisation?

**MR FISK:** I think the papers tend to indicate that the organisation was called -- the paperwork that I've read indicates Eastlands is described as "formerly Moerangi Treks".

**MR McCARTHY:** So if Moerangi Treks was suspended, and Eastlands was approved, would it be fair to say that Eastlands arose once Moerangi was suspended?

**MR FISK:** That's possible.

**MR McCARTHY:** I think it's more than possible, I think it's apparent, wouldn't you say?

**MR FISK:** Happy to agree, I guess all I'm saying is I can't see that off the paperwork, but I agree with your assertation.

**MR McCARTHY:** We were discussing before the "how" question and one of the possible explanations was a lack of internal communication.

**MR FISK:** Yes.

**MR McCARTHY:** Another possible explanation might be the need for these specific type of programmes, so the evidence we've received suggests that there's a desperate need to find a place to place children. Is there still a desperate need to find suitable organisations today?

**MR FISK:** You'll need to address that question to Oranga Tamariki. Providing foster care is, I think, folks know it's hard to do, but again, it's outside of my jurisdiction if you like.

**MR McCARTHY:** But you'd posit that whether there is desperate need or not, that doesn't factor into your accreditation process.

**MR FISK:** No, part of the reason I take an independent view is that I then, my staff and I am not subject to pressure along the lines of "No, no, no, you can't close that organisation, it's the only organisation in place X that delivers this service."

**MR McCARTHY:** One final explanation that I wanted to explore with you was related to the nature of the programme itself. So we discussed previously how Moerangi Treks was a programme set up in Te Urewera as a programme for Māori boys, and from the documents we've received it seems that there was a reluctance to challenge these types of organisations because there wasn't a level of cultural competence or cultural expertise within the accrediting organisation.

So my question for you is, is there a level of cultural expertise within your organisation as an accrediting entity?

**MR FISK:** My answer to that is that it is an evolving and improving situation. For example, I've appointed a national manager for Māori to increase our cultural competence and capability. So we are taking active steps to do that. Have we got it to the place that I'm satisfied? No.

**MR McCARTHY:** Obviously the types of organisations you'll be accrediting are quite diverse.

**MR FISK:** Yes.

**MR McCARTHY:** I imagine some organisations would be working with Pasifika peoples?

**MR FISK:** Yes.

**MR McCARTHY:** And neuro diverse or people with disabled backgrounds?

**MR FISK:** Yes.

**MR McCARTHY:** What level of expertise do you have in your organisation in regards to these sort of populations?

**MR FISK:** So we have, with the exception, in my view, of enough Māori accreditation assessors, in all other respects the workforce represents the community in which it resides.

**MR McCARTHY:** So the community in which it resides or the community that it serves?

**MR FISK:** Both, because our staff live in, they live in the communities that providers are. So, for example, I have staff from Kaitaia down to Invercargill.

**MR McCARTHY:** But you would agree that the people using social services aren't representative of the general demographs of New Zealand, would you agree with that?

**MR FISK:** Oh, I see, yeah no, no, that is true.

**MR McCARTHY:** We've talked about the possible reasons why or how Eastlands was accredited, and there was a resultant abuse that arose from this. I've included a witness statement in the bundle but for time purposes I'll just read out the types of things that happened due to this.

**MR FISK:** Sure, yeah.

**MR McCARTHY:** So in the witness statement the witness said that they saw boys being hit around the head with shovels, boys (inaudible) being tied to horses and having the horse bolt. One boy being set on fire. All that type of abuse in this instance could have been prevented if the accreditation process was robust, you'd agree with that?

**MR FISK:** The accreditation process certainly did not know about this information. If the accreditation process knew about this, the organisation would not have been accredited.

**MR McCARTHY:** I guess when we're trying to assign responsibility --

**MR FISK:** Sure.

**MR McCARTHY:** -- the responsibility obviously lies with Person B, but would you take responsibility, especially for the abuse that occurred in Eastlands, given the prior knowledge of Person B?

**MR FISK:** Well, I think the Ministry has said it takes responsibility. It's hard for -- I'm not trying to dodge your question, it's hard for me to say because the accreditation, the statements by your witness that we've just discussed, that information would not have been available to that accreditation or approval process. It would not, in my view at least anyway, that approval process would not have occurred had that information been available.

**MR McCARTHY:** But this is abuse that happened in Eastlands.

**MR FISK:** Yes, that's correct.

**MR McCARTHY:** There was information available about the abuse that happened in Moerangi Treks, wasn't there?

**MR FISK:** Yeah.

**MR McCARTHY:** So if we're looking at the accreditation process, and if it was aware of Moerangi Treks abuse that is very similar to the Eastlands abuse that occurred, there's a degree of responsibility that falls on the accrediting organisation.

**MR FISK:** Agreed.

**MR McCARTHY:** Now, another programme that has quite extensive interactions with the Community Funding Agency was Whakapakari. Whakapakari was approved in 1994 and its approval continued through until 2004.

**MR FISK:** That's correct.

**MR McCARTHY:** When we look at -- I probably don't have time to get into the details of each incident that happened at Whakapakari, but what I took overall is that Moerangi Treks, it demonstrates that the initial approval wasn't appropriate and when I look at Whakapakari, it would appear that when we were talking before about the warrant of fitness, when the re-approval or re-accreditation process wasn't appropriate, so today when we look at issues that may arise, what processes are in place to ensure that those issues are addressed and that the organisation is fit and safe for purpose?

**MR FISK:** Sure. So I think if we start where you are with the Moerangi Treks and Whakapakari complaint was received, in this case if we go to the key organisation which was Oranga Tamariki, they would carry out their investigation. If there were more agencies involved with that organisation then there'd be a group meeting about that. The appropriate investigation would take place and then we would follow up and decide what action should be taken. We can suspend and what that means is the organisation has no contract, so at the point that I make a decision to suspend and it gets gazetted, that organisation cannot continue to contract with Government.

**MR McCARTHY:** Could I stop you there, because I think I may have misstated the question, just so I can be clear.

**MR FISK:** Sure.

**MR McCARTHY:** There's things that fall into the purview of Oranga Tamariki and you've described the process that happens in that instance. But, for example, things that fall into your purview, does vetting still fall into your purview?

**MR FISK:** Yes, so I check on vetting, if you're asking me that.

**MR McCARTHY:** If a vetting issue arose when you're going through, and perhaps it didn't rise to the point of suspension, but it needed to be addressed, what processes are in place to ensure that they are addressed?

**MR FISK:** Sure. Okay, so our staff visit, they look at the vetting, and matters relating to the Vulnerable Children's Act and Children's workers to make sure the appropriate documentation is available and evidenced. If there are gaps in the vetting the organisation is given six weeks to fix that, if they do not address matters like vetting and other things that are requirements in the standards, then we go from a critical action, for want of a better word, which is time bound, and if that's not resolved, then that does go to suspension, and then they get a period of time to fix that particular failing.

**MR McCARTHY:** And I know it's been a limited amount of time Te Kâhui Kahu's been operating but have there been any suspensions or what's the frequency of suspensions?

**MR FISK:** We have done seven suspensions in the last 12 months. Of those, two have -- are no longer providing services, one relinquished and one got revoked. The balance that were suspended addressed the issues within the time period and are now back delivering services but on a shorter timescale. So for example, one that I can recall, they're on a six-month cycle not a two-year cycle.

**MR McCARTHY:** And going back to our question before about, I know you didn't accept the characterisation of a Phoenix organisation, but one can imagine a scenario where there's an organisation that was suspended, and the director of that organisation may not necessarily be accused of abuse, but they facilitated it within their organisation. What safeguards are in place to ensure that that individual, that those individuals are prevented from starting a new organisation and re-applying for funding?

**MR FISK:** I don't know whether I could call them specific safeguards but it's a combination of things. We use the New Zealand business number to actually identify organisations and all the information relating to them, and that gives us all the information about the staff and the directors. But in the end, the most effective way of this, managing this, is our people on the ground. That's the most --

**MR McCARTHY:** So the body of the staff that you have --

**MR FISK:** Yes, that's the most effective way, there's no particular easy way to systematise this.

**MR McCARTHY:** One final question I had was in relation to Te Tiriti, Treaty principles. During the accreditation process, what standards are used to ensure that accredited organisations operate in accordance with Te Tiriti?

**MR FISK:** There's a cultural competency standard within the suite of standards and that is used. And that's used for all organisations.

**MR McCARTHY:** So a part of that cultural competence would be knowledge of Te Tiriti?

**MR FISK:** Yes, and that being designed into services that are being provided.

**COMMISSIONER ERUETI:** Can I ask you about -- excuse me, one second -- about having the capacity also to -- for your organisation to determine whether these organisations are meeting that criteria?

**MR FISK:** Sure. Yeah, so for example, we do look for specific evidence. We would not be so brave as to suggest that we might ask a Māori or kaupapa Māori organisation to prove to us they were culturally competent, but we are interested in bigger organisations and large, I guess, multi-skilled organisations of which New Zealand has a big number of large organisations, we'd expect them, who are delivering services to Māori, to be able to demonstrate how they were meeting those standards. Similarly for Pasifika, but also for other groups.

**COMMISSIONER ERUETI:** This would turn on your organisation having the expertise internally to be able to assess their compliance with those standards. I know you mentioned a national manager for Māori, but you're still taking steps, I think you said.

**MR FISK:** Yes, that's correct, to build that capability and capacity.

**COMMISSIONER ERUETI:** Thank you.

**MR McCARTHY:** I don't have any further questions for you, Mr Fisk, but thank you for your evidence, I'll pass the time to...

**MR FISK:** Thank you.

**COMMISSIONER ERUETI:** Can I just use this opportunity to quickly follow up on that question. So that question related to current practice. Are you able to talk about prior practice about the degree to which providers were assessed for their compliance with Te Tiriti obligations?

**MR FISK:** I reviewed the Community Funding Agency standards. They're not as extensive as the standards that we used today. There was some -- there was some testing in there, but not as much as I think what you're -- you would expect.

**COMMISSIONER ERUETI:** Yes, okay.

**COMMISSIONER STEENSON:** Can I just ask something for clarification about -- so my understanding of what you've just said is you require larger organisations to prove cultural competency around Te Ao Māori; is that correct?

**MR FISK:** I probably didn't represent that well. I simply gave as an example of organisations that deliver a range of services, including to Māori and we would test that with them, but our organisations that we work with are from three-people organisations through to organisations with several hundred staff.

**COMMISSIONER STEENSON:** Yeah, I guess that's my question, is that a different standard for smaller providers?

**MR FISK:** It is in fact the same standard but it's tough for them, and so we have to be cognisant of that.

**COMMISSIONER STEENSON:** For the smaller?

**MR FISK:** For the smaller providers, yeah.

**COMMISSIONER STEENSON:** Thank you.

**CHAIR:** Dr Cooke. Tēnā koe.

**QUESTIONING BY DR COOKE:** Tēnā koe, Madam Chair. Tēnā koutou, tēnā koutou, tēnā koutou katoa. Again, I'm one of the Counsel Assisting the Commission, ko Allan Cooke tāku ingoa.

Mr Jones, I'm going to be asking you some questions, I'm mindful of the time as well and I'm not going to be able to question you on every matter, of course we could do so, and I'm likely to miss an emphasis and I may likely go down a rabbit hole and if the need arrives we'll follow up that. For those watching, I am possibly the greyest or the whitest-haired of us here today, I am Pākehā and I'm also one of the older ones, and I'm wearing a dark charcoal-y suit with a tie and a white shirt, and glasses.

Now, I just want to start with your background because I know that you have been across the Public Service both with MSD and OT, it would appear, in their various incarnations for some years; is that correct?

**MR JONES:** Mostly with MSD actually. There was a period of time just for a couple of years where I didn't work for Oranga Tamariki but was involved in the establishment of Oranga Tamariki.

**DR COOKE:** And because of that you would be well familiar with the history of Oranga Tamariki, Ministry of Social Development, Child, Youth and Family services, etc.

**MR JONES:** That's correct. Actually, before I go on, tēnā koe, Mr Cooke, and also just to explain myself. I am a 50-year-old Pākehā male, salt and pepper beard, wearing a grey jacket and a shirt that looks like an explosion of forests.

**DR COOKE:** So we've established that, that you are -- you've told us in your brief that you can speak to the National Care Standards --

**MR JONES:** Correct.

**DR COOKE:** -- both currently as they've been and as what's going to occur, but you can also come to us with an informed knowledge of, in recent years, the care system.

**MR JONES:** As much as I can, I don't have a social work background as such, unlike a lot of my colleagues in the monitor, but I do have a high-level understanding, correct.

**DR COOKE:** Yes. I was particularly noting that you were leading the partnership and programmes work stream in the investing in children programme that established Oranga Tamariki.

**MR JONES:** That's correct.

**DR COOKE:** And would you accept the proposition that in order to understand the present and hopefully have a good understanding of what may occur in the future, we have to understand the past?

**MR JONES:** I would agree.

**DR COOKE:** Would you agree with the further proposition that the care standards as we now have them were introduced because it was transparently clear that Child, Youth and Family, as it was, or whatever it was called at this time, was failing in its duties in respect of children in its care and custody?

**MR JONES:** I think it's important that we have very clear, and there's minimum, what I would describe as minimum standards of care, that we have them in place so that people note what to expect. As I say, as a minimum. And also as a measure, so we know that actually if care is being delivered successfully.

**DR COOKE:** Can we go back to my question, which was the care standards were introduced because there had been a clear failing evidenced over many years, including numerous reports that had been published, and I could go back to the 1988 report of Death of a Child, I think, there's Poweo(?), there is the Mason report, there is the Brown report, there is the Mel Smith report, we had various other reports, they were all indicative of an organisation and an institution that was not meeting its -- the needs of its clients, wasn't it? That's an accurate statement, isn't it?

**MR JONES:** I would agree, there was improvements to the quality of care that were needed and, you know, we produced our first report on the compliance with those care standards this year, early this year, and what it shows is there is still work to go in terms of improving the quality of care. At the same time, there are also areas that are being delivered well.

**DR COOKE:** Yes, and we'll come to that. The other aspect just on the history is that the care standards, they were drafted in-house, weren't they, as I understand it?

**MR JONES:** That's correct, but also in consultation.

**DR COOKE:** Yes, there was consultation with the New Zealand Law Society, the family law section, and various other stakeholders.

**MR JONES:** That's correct.

**DR COOKE:** So they were an internal exercise which was a recognition of what we've just -- what you've just agreed with me was a failure on the part of Oranga Tamariki to be able to meet the needs of its very vulnerable clients?

**MR JONES:** The representation of what we should expect in terms of care and support for care givers.

**DR COOKE:** And in both of those respects, those matters were not being met, were they?

**MR JONES:** That's the purpose of the monitor, is to assess whether those standards are being met, and --

**DR COOKE:** And we know, don't we, that prior to the introduction of the care standards, there was no equivalent, therefore there was a void, and we also know, as you've told us in your report, that even now, that Oranga Tamariki cannot satisfy you that it's meeting the care standards themselves.

**MR JONES:** Look, I'd agree, prior to the care standards being put in place there were no previous care standards.

**DR COOKE:** Yes. And in fact, if we look at the residential area, the only regulatory framework were the residential care regulations, weren't they?

**MR JONES:** To my knowledge, correct.

**DR COOKE:** As far as for the vast number of children who were in care, those who went into foster care, family homes may have been placed with NGOs, there was no regulatory framework, was there?

**MR JONES:** Well, there is to the extent that the Children's Commission had the mandate to monitor the Oranga Tamariki Act, or the Child and Young Person's Act as it was then, so that -- there was that capacity.

**DR COOKE:** There was a capacity by a third party, but in terms of a regulatory framework, that was around the institution responsible for taking children into care and being responsible for their care, there was no framework.

**MR JONES:** I would agree with that, yes.

**DR COOKE:** And that's notwithstanding the fact that the Chief Executive has had, where there's a sole guardianship order or a custody order, has the responsibility for the safety of children, which is a legal responsibility, isn't it?

**MR JONES:** I think these care standards are a significant milestone in terms of setting standards and then measuring performance against them, which is a step towards ensuring that we have quality of care.

**DR COOKE:** Right. Now, there was a discussion earlier on about independence, and leading into that there's the proposition that I put to you that one of the issues that Oranga Tamariki now has, and this is well known because, for example, the controversies that have followed it since its establishment, which include, for example, the Hastings uplift and various other matters that we know about, pēpē being uplifted on a without notice basis etc, has created major perception problems for it, hasn't it?

**MR JONES:** Yeah, I'd agree with that.

**DR COOKE:** And would you agree with a further proposition that I would put to you, and I say this as a practitioner at ground level in South Auckland for many years, that there's little -- there was little distinction between with the transition from whether it was the Department of Social Welfare, as it was, through to Department of Child, Youth and Family Services and its various incarnations through the 90s, and I think there may have been five or six changes of name, quite a few changes of control, was it a stand-alone organisation, was it within MSD, that kind of thing, and then finally there was Oranga Tamariki. For those who were dealing with it, and particularly for whānau, it was a pretty -- it was a continuous stream, wasn't it, if I use that analogy? There may have been a ripple or too as the name changed and the logo changed, but beyond that, people dealt with social workers, exercise of statutory powers and life continued.

That's the reality of it, isn't it?

**MR JONES:** The purpose of the organisation stayed the same throughout, so I'd agree on that. The purpose of the organisation is to keep tamariki safe.

**DR COOKE:** And now, let's proceed on the premise of course that where we're at now is trying to turn the Titanic around before it hits the iceberg, it may already perhaps be getting very close to the iceberg, if you accept that analogy, that we have a major perception problem, don't we, out in the community towards the institution of Oranga Tamariki?

**MR JONES:** I think that's one of the opportunities that the monitor provides. We're here to provide trusted, impartial information both in terms of performance in data but also through listening to the conversations of those in the community and to bring the voices of experience forward into public reporting to provide a view of the experience of care.

Sometimes we can get caught up in incidents which can reflect how we might view wider practice. Likewise, things haven't always been as visible as they perhaps could be, and how I see the monitor is an organisation that is to try and make information available that can be a trusted friend of how things are that can perhaps fill some of the voids where

information has been lacking and also provide assurance around information that is already out in the community.

**DR COOKE:** I think we're saying the same thing, which is in terms of the work you're doing, and you're the Executive Director -- am I to understand it?

**MR JONES:** That's correct.

**DR COOKE:** -- of an institution or a separate or somehow autonomous body within MSD which is the monitor.

**MR JONES:** That's what I am, the Executive Director of the monitor.

**DR COOKE:** Yes. Are you the monitor?

**MR JONES:** No, I'm not the monitor. What you'll see in the Bill that's before the house is it actually establishes the monitor in law as a chief executive and as a statutory officer.

**DR COOKE:** You're established under Section 447A of the OTT Act, and I haven't got that to bring up, but it does say that the minister must appoint an agency or a body independent of the department to then carry out the various roles.

**MR JONES:** Yes.

**DR COOKE:** So there is a monitor established within MSD and you're its Chief Executive.

**MR JONES:** No, sorry, I'm the Executive Director of the monitor, of the monitoring function, but that does not make me the monitor in law.

**DR COOKE:** No, I understand that.

**MR JONES:** The minister has delegated that responsibility to Debbie Power and she is, yeah.

**DR COOKE:** As a public servant working within MSD, are you subject to directives from Ms Power in terms of your role as the --

**MR JONES:** Executive Director.

**DR COOKE:** -- Executive Director?

**MR JONES:** I haven't received any.

**DR COOKE:** That wasn't my question. Are you subject to directions, would you be subject to directions from her in carrying out your role?

**MR JONES:** As part of -- I'm an employee of the Ministry of Social Development, so to that extent yes, but in terms of our arrangement, we've been very careful, and like I said earlier, to ensure that the monitor as it is being established is effectively adjacent to the Ministry of Social Development. Now, of course, we're in this phase of establishing the monitor at the moment and the permanent status of the monitor is the subject of the Oversight Bill that is in Parliament.

**DR COOKE:** Yes, I'll come to that. You mentioned that you have an arrangement with Ms Power. That was the word you used. Tell me, is that a written arrangement or is it a verbal arrangement, and what are the parameters of the arrangement?

**MR JONES:** So Debbie has formally delegated me the responsibilities to carry out the monitoring of the National Care Standards.

**DR COOKE:** And does that include, if we go back to Section 447A, this notion of independence, that you are able to say to her, or to others, in terms of the delegation I have received, I am independent from.

**MR JONES:** In terms of -- to say that I'm formally independent of the Ministry of Social Development is not true. I'm an employee of the Ministry of Social Development. The Chief Executive of the new monitor, once it's fully established, will be a Chief Executive and that's quite a different kettle of fish.

**DR COOKE:** You tell us in your brief that you are employed in your current role for two and a half years. That's going to end towards the end of this year; is that correct?

**MR JONES:** I've just had my contract extended just to cover the period until the departmental agency, if that's what's finalised, goes forward.

**MR FISK:** Right, okay.

**AUDIENCE MEMBER:** Make the community safer.

**DR COOKE:** Again, just sticking with this independence notion for a minute and picking up on what Ms Toohey asked you earlier, there is of course, as you know, some controversy around the oversight legislation, and she alluded to that of course in terms of the -- going back to the Beattie Report, and you will be aware of those matters. Is it within your ability, your capacity today, to be able to offer your view, given your current role, as to the legislative proposals that are in the Bill and whether or not what is proposed is a good idea or not, having regard, for example, to the recommendations of the Beattie Report?

And I also note the concerns around what is going to be happening to the Office of the Commissioner for Children.

**MR JONES:** Look, the Beattie Report made or put forward a number of options for how the oversight system could be structured. She recommended one for expediency and one in terms of cost that the monitor could be housed within the Children's Commission. We had certainly been working on that assumption for a time.

But look, this is a decision for Government to make in terms of how these are structured. What I'm focused on at the moment is getting the monitor ready to deliver its

monitoring function across the whole of the Oranga Tamariki system, irrespective of what our status is.

And there's another part to it too, we have conversations with the Commissioner and with the Ombudsman's office about how the oversight system will operate as three separate entities. I might want to give you an example of how I see that operating. For example, the Ombudsman's office deals with complaints, they carry out investigations. Sometimes those complaints will show systemic issues and they may make recommendations on how they are best addressed.

By the three organisations working together, and sharing that information, which is what is proposed in the Bill, the monitor, because we have kaimahi that go out into communities, speak with tamariki and rangatahi, speak with carers, speak with whānau, speak with agencies, we can help the Ombudsman's office to understand whether those recommendations, one, have been put in place, and two, what is the difference that they are making, and then it is for the Children's Commission, or the Children's Commissioner in her role, if things aren't being improved, then she can be that advocate and she can speak and make recommendations on what needs to change.

I think that's a good practical example of how I see the three parts of the oversight system working and we're already discussing about how that operates.

**DR COOKE:** I appreciate that. Let's go back a little bit, which is around the controversy or the debate around that tripartite system. Did the monitor and/or you, or were you involved as the Executive Director, put in any policy submission or proposal to your minister which would have gone to Cabinet around the final make up that we now have in the Oversight Bill around that tripartite system?

**MR JONES:** The responsibility for the policy work and development of the Bill sits with the DCE for policy within MSD. We were consulted on the practical applications of what was being proposed, but it was not my role to make submissions on the final form.

**DR COOKE:** All right, I wonder if we could bring up, we're going to try and bring something up, it's going to be MSC 008450-035. And with luck something may emerge. Can we go to 35.

**CHAIR:** Just to say that this is the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill, and you're wanting to go to, which part of it?

**DR COOKE:** I want to go, in fact it's the previous page by the looks of things. There we go. Can we come in on Section 12 which is the independent monitor established.

This is the provision you knew by heart, almost, and you cited it earlier.

**MR JONES:** No, it's not the one I cited.

**DR COOKE:** I'm going to go to that one, but this is the one that establishes the independent monitor, isn't it?

**MR JONES:** That's correct.

**DR COOKE:** And as I understand the evidence of your colleague earlier today, you are going to -- it's an independent monitoring agency which isn't in the same category as, for example, the Ombudsman but a next tier down, is it?

**MR JONES:** I think -- yeah, look, it's the not a Crown entity, it's a departmental agency, at least that's what's proposed in the Bill. I think what's clear is that it has to be independent of the agencies that it monitors. That's why when this Bill passes, or at least commences, we all have to leave the Ministry of Social Development because they will be one of the agencies that we will be looking at the performance of.

**DR COOKE:** You're going to be, as I understand it, you're going to be placed within ERO?

**MR JONES:** They will become the host, we will be operationally autonomous from ERO. We like to see it as they provide us with, you know, power, rations.

**DR COOKE:** So you'll be in their building.

**MR JONES:** No, that's not the case. We have offices in Ōtautahi, in Tāmaki Makaurau and in Whanganui-ā-Tara and they are separate offices from ERO and there are no current plans to be housed or collocated with them.

**DR COOKE:** So, essentially, they will be providing admin services to you of various types?

**MR JONES:** Yes, as I described to my team, on day 1, ostensibly they won't see a difference in terms of their day-to-day work or how they operate from being hosted by MSD or hosted by ERO, we stand on our own.

**DR COOKE:** And if we can go on to one more page, and another one, I want to go to 16A. "The duty to act independently". Again, you're saying to us that this is the reassurance that the public at large has around the integrity of the work that you'll be doing, that you're acting independently when you're carrying out the two primary functions that are set out there.

**MR JONES:** That's partly it, but I think in terms of the public at large, what they see is what they experience when we go out and meet with them, and the way that we engage with them and also through our reports.

**DR COOKE:** It's important, isn't it, that you are seen in the same way that perhaps the Children's Commissioner is at the present time and the Ombudsman has been for many years, that you are going to be an organisation of integrity, that is going to carry out its statutory duties with transparency and that you will be beholden to none.

**MR JONES:** So there are a number of things that we do to ensure that. You know, I could provide a long answer to this but I'm conscious of the time, because there's been a lot of engagement that's been undertaken since 2019 with Māori leaders and providers and with agencies in New Zealand in general about what they are looking for. Having a trusted source of information is crucial and having the transparency, that's why all of reports that we produce will be published, and in fact the main ones will be tabled in Parliament as proposed in the Bill. Along with the agencies that are required to respond to those reports, they are published also.

**DR COOKE:** Just finally on the question of independence, and that is the issue of funding. And I know that you've said, I think in your brief, that there aren't any issues around that, is that -- that's the position, isn't it? I think I read that somewhere.

**MR JONES:** That's correct. We can operate within our current budget.

**DR COOKE:** And within your current budget you're able to go out, I know you've been to places, you've been over the motu, you've been to Gisborne, you have been to various places in the South Island, you've been up north, do you have a programme that's in place for that kind of activity?

**MR JONES:** Certainly. We have a plan, we have a three-year plan for how we visit communities right across Aotearoa, and then also a plan which will start in terms of carrying out deep dives in thematics around particular areas of interest, as well as the plan to do the broader monitoring of the whole of the Oranga Tamariki system once the Bill commences.

**DR COOKE:** We'll come back to that. I want to now just cover the question of the children that you're going to be looking at. And I wonder if we can bring up ORT 006741-005. It's going to be Regulation 3 of the care standards I think.

**CHAIR:** If you could just say what we're looking at here.

**DR COOKE:** This is the Oranga Tamariki National Care Standards and Related Matters Regulations. And I want you to look at Regulation 3, clause (1). This covers those children in respect of whom you have jurisdiction, doesn't it?

**MR JONES:** Current jurisdiction, correct.

**DR COOKE:** Current jurisdiction at the present time.

And so you'll see that it applies to children, a person aged under 18 to whom Section 386 of the regulations -- of the Act applies, and then it covers those other people, right? I'm interested, first of all, in 3(1)(a). I haven't got it up on the screen but I went and printed off 386A, it has a heading "Advice and Assistance for Young Persons up to the age of 25". And, of course, this was part of the provisions put into the Act I think back in 2017

or 2019, that's designed to ensure that children who leave care are provided with assistance and support, possibly up until the age of 25.

Now, although the section provides for advice and assistance for young persons up to the age of 25, the regulation in fact limits the application of 368A to people under the age of 18.

**MR JONES:** Yeah, I can probably explain why that's the case.

**DR COOKE:** Before you do, can I make this comment, or this observation, because as I would read it, it tells us that there is a significant cohort of vulnerable young people who have been in care and who have transitioned from care and who may need your oversight and guidance, making sure the standards are kept, who are missing from your jurisdiction.

**MR JONES:** Look, what Government decided in establishing the monitor is they put in place, I've mentioned it in my brief, a phased approach because what we're doing is establishing a new function. First, they asked us to stand the monitor up and then start monitoring two of the National Care Standards.

We produced three reports on those care standards and they relate to allegations of abuse and neglect for tamariki and rangatahi in care.

The next stage that they've asked us to do is to monitor the care standards, the whole of the care standards, as described in this regulation.

Now, the final part, and I think this is the answer to your question, Mr Cooke, is that what the Bill then allows for is the monitor to expand its scope to look right across the Oranga Tamariki system, including the provision of support which I agree is crucial to rangatahi aged 18 to 25. So we will get to that.

And I am impatient, as it sounds that you are, for us to start that monitoring. Because as we travel around the country, meet with providers and communities, what they want us to start monitoring is all the work that is being done to prevent tamariki coming into care in the first place as well as how whānau are supported to keep those tamariki in those homes. And also, how we care for our rangatahi when they leave care to make sure that they can have successful lives.

So I am as impatient as you, Mr Cooke, to get to that work.

**DR COOKE:** Let's go back to the provision though, and let's talk about the care standards. The care standards, as they read today, and that we haven't -- you're going to tell us they'll have to be amended in order to do what the Bill says.

**MR JONES:** No.

**DR COOKE:** Because at the moment the care standards say --

**MR JONES:** Oh.

**DR COOKE:** -- don't they?

**MR JONES:** I think I understand what you're saying.

**DR COOKE:** Do you understand what I am saying?

**MR JONES:** You'll need to allow the care standards -- yeah. I feel like I'm back in law school at the moment. I am doing my best here, but I think you're right.

**DR COOKE:** You think I'm right? That's good.

So it will also mean, doesn't it, because I know you talked about a staged approach, and I'm going to talk about that, we'll probably come to that now. You're saying the staged approach was in respect of allowing your work to be undertaken.

**MR JONES:** You have to learn to walk before you can run, I think is a way to describe that.

**DR COOKE:** Because I was going to ask you that question in relation to Oranga Tamariki, and let's go back, the care standards were the subject of, the care standards 2018, and know that negotiation, consultation occurred prior to that because I was involved in it, they were in the process of being drafted and the policy formulated around that, it must have been sometime earlier. You would agree with that? They don't just come out of --

**MR JONES:** No, there was probably considerable work, I wasn't involved in it, but there would have been.

**DR COOKE:** There were statements made around the time of the care standards coming into play, into force back in 2019, and I remember one expression was "Don't expect too much, it's going to be incremental, not radical and big bang as of 1 July". Now, that was a statement that came out on MSD or OT letterhead at the time, as I recall, but I haven't got it with me so I can't wave it in front of you.

But it would seem that the staged approach has also been a reason or a just -- is it being used by OT in some way to enable them not to comply to the extent that you would want in meeting the care standards, their own care standards, which they promulgated and which they -- which are the regulations which came into force back on 1 July 2019.

**MR JONES:** I think the best thing in terms of where Oranga Tamariki are with their compliance with the care standards is in our first report on those care standards which is on our website and was published in February, yes.

**DR COOKE:** I'm going to come to that.

The other thing, given we've spoken about this vulnerable, this issue of potentially vulnerable children who may miss out but who will now be captured by the amendments subject to the care standards being changed, relates to those children who have a neuro

disability or of whatever type, and I'm mindful of those children with FASD in particular, because we know that there are far more children in care who have FASD and related disability issues than are formally acknowledged. Do you agree with that?

**MR JONES:** That's not an area of my expertise, but I do know it's of concern, yes.

**DR COOKE:** This Commission had evidence from an expert called Valerie McGinn, and I couldn't see if her document was on our bundle so I couldn't find it, but I'm going to just relay some of the evidence that she gave.

She told us there had been no research here on FASD in Aotearoa and that overseas data is relied on. It's estimated that 30 to 50% of children in State care have FASD.

So that is -- she's an expert, she works in this area with the FASD centre and does lots of reports for Oranga Tamariki, for example.

That would be a significant cohort of children, wouldn't it?

**MR JONES:** Based on how you've described it, yes, it would be.

**DR COOKE:** I'm just assuming for the present time that that's a statistic that's -- it's broad, 30 to 50%, but even at its lower limit it's a significant statistic. And she talks about the prevalence of FASD in the general population is about 4%, children taken into foster care are of course a higher risk group, and there are significant risks for those children if the care system, Oranga Tamariki, fails in any respect, and you would agree with that?

**MR JONES:** What I would agree with is that where children have needs, those needs should be met so they can have the best possible outcomes.

**DR COOKE:** And part of that, of course, is through the care standards, is identifying what children need.

**MR JONES:** Yes. So, for example, the care standards require that health assessments are made and that those children are connected up with health services so that their needs can be met.

**DR COOKE:** And they also require Oranga Tamariki to have children undergo gateway assessments and other various things, don't they?

**MR JONES:** Yeah, it puts on minimum standards for what you'd expect to see.

**DR COOKE:** Her evidence was also that the response of the Ministry of Health had been to exclude individuals with FASD from all Disability Support Services. She noted that OT had led the way in diagnosing and providing services to many children in care who had FASD but was nonetheless, she said, a drop in the bucket compared to the number of children who were in care and had FASD, and that was a significant burden on OT.

And I know from, you know, I'm sure we all know if you work in the area, that FASD in kids in care, whether it's in the care system or in YJ, they are everywhere.

**MR JONES:** Is it possible for me to make a statement about how the monitor, through our practice, can address this and other health issues of tamariki? I'm just not sure -- would that be helpful?

**CHAIR:** I think that's possibly where you're going -- is that where you're going?

**DR COOKE:** I was going to but -- I was going to bring up a document where there's a comment made around that, which is --

**CHAIR:** And we don't want to stop you, let's just let Dr Cooke go on and then feel free --

**DR COOKE:** Which is BAR 0000720-0033. If you could hone in on the second full paragraph "Developing comprehensive" -- next one down.

**CHAIR:** What is this document?

**DR COOKE:** This is part of your report and it tells us that developing comprehensive systems is going to require help from other agencies and there's an example here that "matauranga requires information to be made available by Ministry of Education" and we could translate Ministry of Education across to Ministry of Health, I assume, if we're talking about kids and health.

**MR JONES:** I think that paragraph refers to -- one of the key findings in our report speaks to collaboration between agencies, because what needs to be remembered is that the monitor in monitoring the care standards as well as when we monitor the whole system isn't just focused on Oranga Tamariki, we're focused on all parts of the system that support tamariki in care or that are in the system. And so that is why it's important for us, when we're in communities, to be listening to, again, tamariki, caregivers, whānau and agencies about how -- what are the barriers to delivering good care, what are the things that are working well, and for us to provide insights around that so we can start to see change. And then what the monitor does is we keep going back.

So we go once, we go back again, and we go back to see: have those things been done and are things getting better? And that's our kaupapa.

**DR COOKE:** Because one of the -- an issue for many who are involved in this Commission is that -- is the disparity between what happens up here, the theory at the top --

**MR JONES:** That's correct.

**DR COOKE:** --and what happens down on the ground.

**MR JONES:** The approach that the monitor takes, again, is we receive data, performance or assurance information from the Government agencies and then we spend a considerable resource, over half of our kaimahi are focused on going out and engaging in communities. So since January 2001 we have spoken with more than 280 tamariki and rangatahi, over 70

whānau members that have tamariki in care, 260 caregivers, 1,500 other people, and this is professionals or people that work for agencies, to understand what is actually happening on the ground, what are the things that are getting in the way, whether they are culture, leadership, people, or tools, and we use that information to develop insights, also as a way of validating the data and information that you get from agencies to make sure what is being said at the centre is actually what you are seeing and experiencing on the ground.

**DR COOKE:** How, then, do you ensure that children who are on the ground and need to have, and use a practical example, they may have some sort of -- they may have suffered some brain damage at birth or there's been an accident and they're in a special class at school, they may need a teacher aide, they may need whatever, and of course at the present time there are all sorts of hoops that people have to jump through to make sure that they can get necessary assistance for those children. And sometimes we know, and let's assume as well possibly there may be a mental health issue.

Now, I don't know what the experience is elsewhere but here in Auckland if we want to get Child and Adolescent Mental Health involved it's really a wing and a prayer, and everyone's nodding, which is good to see.

**MR JONES:** It's not good to see at all, I think it's quite the reverse.

**DR COOKE:** It's good to see that there's agreement with it.

**MR JONES:** Well, I think, Mr Cooke, that's actually called out in our report in terms of the challenge particularly in mental health services of whānau and caregivers engaging with those services to support tamariki in their care.

**DR COOKE:** My question though is, given your role, do you have an active role to play in assisting the break-down of structural divides that exist between, for example, the Ministry of Health, or whoever delivers child and adolescent mental health services, and those responsible for the care of children, like Oranga Tamariki, and/or the Department of -- Ministry of Education, do you have a practical role in breaking down those barriers.

**MR JONES:** So if I can describe how I see it operating, I think the answer to that question is yes, but it's a bit more complex.

So, obviously, what we're doing is developing insights about what is working well because it's just as important to identify good practice for people to follow, as it is to identify the barriers that are preventing quality of care. We then put that information into our reports that we provide to the Minister for Children, which I've described. He then, it is a "he" at the moment, he asks those agencies to respond.

So what the monitor does is, we're very interested to see what agencies, and here I talk about Ministry of Education, Health, as well as Oranga Tamariki and others, on what they are doing. And they set that out in their response. It is then the role of the monitor to go back again and say, "You said you would do these things. One, have you done them?" Two, we are back in communities to see if you have done them, are they making a difference, or what else might be in the way that's preventing success, and we report on that, we publish those reports and on it goes.

That's how the role of the monitor is there to help drive one, accountability, but also to support change.

**DR COOKE:** On that last point which is you're there to drive accountability; you don't have the power to enforce anything, do you?

**MR JONES:** No, so Government agencies aren't accountable to the monitor currently, nor would they be under the -- as ascribed in the Bill. Those agencies are accountable to their minister and then the minister out to the citizens of New Zealand, so that is where the accountability lies. Our role is to provide trusted information that others can rely upon to make better decisions, whether those are people in communities, or people at the centre, and likewise, we can rely on my colleagues, the Children's Commissioner, and the Ombudsman to carry out their role as both advocate and as someone that can handle complaints and carry out investigations.

That's why it's important, I think, to see the oversight system in its entirety of working together.

**DR COOKE:** In your reports, do you have a power of at least recommendation?

**MR JONES:** Yes, we can make recommendation if's we choose to.

**DR COOKE:** As I think as the Ombudsman can do.

**MR JONES:** Yeah, the Ombudsman is free to make recommendations and we could also make recommendations.

**DR COOKE:** Have you made recommendations.

**MR JONES:** Not to date.

**DR COOKE:** Does that mean that the ability to make a recommendation on one or more particular discrete aspects is going to be something that will be reserved for significant matters?

**MR JONES:** We're committed to seeing an improvement in the quality of care. At this time I'm not sure that's best served by making recommendations, but if we felt the need to, we could.

**COMMISSIONER ERUETI:** Just to be clear about that you don't see this as an advisory function in -- because reading your report you do talk about this issue of there not being a holistic approach towards Care and Protection, the silo effect, and so forth, and you say that you're going to do some future work on this, but is that future work is still kind of gathering data and presenting that to the Minister rather than actually taking it, analysing it and then providing advice to the Minister?

**MR JONES:** A couple of things, I think, in terms of as we're building to our fully mature state. One, what we're moving towards is -- and we started off very carefully in terms of the data that we take in, we want to make sure that any information we take we need, and build slowly rather than try and gather more than we require, but we're stepping into a space now where we're not just looking at measuring compliance with the care standards but actually looking at outcomes reporting.

So I'm very keen not just to be able to see whether kids are enrolled in school, I want to know whether they are being successful. So we will start to be able to provide data in that sense as we start to grow.

Now, the other element that we have at our disposal is the ability to do our own initiative reviews, more deep dives. So, for example, we are at the moment planning to do our first one of these, which is around tamariki and rangatahi that are in custody of the Chief Executive but otherwise have remained with their whānau, or who have returned home to whānau and those orders remain in place.

So there, we're going to do a much more deeper dive and analysis of what might be happening in that area and then we will report that to the Minister and publish it.

Now, whether that would contain recommendations, I don't know until the work's been done. But certainly our approach has been, and is, is that recommendations aren't necessarily helpful. I have concern that the role of the monitor is to be a trusted source of information that does not have an agenda, that our information is helpful for communities as much as it is helpful for Government as much as it is helpful for Government agencies.

My concern is, if we start to make recommendations or provide solutions, then we could be seen as having an agenda, I wouldn't want that. Second point is, I think the solutions are best placed to come from the communities themselves, because these are complex problems that we are looking at, and solutions in one community could be different to those in another. And so our role is, as I've explained, we will look for insights, and then we'll go back to see if change is occurring.

**COMMISSIONER ERUETI:** Is there no advisory function written into the legislation for you?

**MR JONES:** There isn't an advisory function spelt out in the legislation. The Children's Commissioner could have that role, particularly when they have, as proposed, a range of commissioners to sit on the board, it would bring expertise and they may well be able to or would want to offer solutions or make recommendations.

**COMMISSIONER ERUETI:** That's within their advocacy function?

**MR JONES:** Yeah, off the back of the information that we have in our reports.

**COMMISSIONER ERUETI:** Thank you.

**DR COOKE:** Just on this question of getting up to full steam. You're currently at stage 2 you tell us in your brief at paragraph 4.4(b), and the third stage, which is monitoring the whole of the Oranga Tamariki system which is everything, it would appear, is dependent upon the Oversight Bill being passed.

**MR JONES:** That's correct.

**DR COOKE:** Are you aware of what the timeframe for that is?

**MR JONES:** Advice has gone to ministers around the commencement of that legislation. What's in the Bill at present is it commences no later than 1 July 2023 or sooner by order in council.

**DR COOKE:** So you would anticipate that by July 2023, at least, everything will be up and running?

**MR JONES:** Provided the Bill passes in its current form, that would be the case.

**DR COOKE:** When you talked about it's the Oranga Tamariki system, just to be clear around that, that's going to be all children who are in the custody of Oranga Tamariki, all children who are in the custody of a third party NGO such as Open Home Foundation --

**MR JONES:** They're already monitored by us, Barnardos and Open Home.

**DR COOKE:** So we have Open Home Foundation who seem to have a large cohort of kids in comparison to Barnardos and Dingwall -- well, Dingwall's out now anyway.

**MR JONES:** That is correct.

**DR COOKE:** Barnardos I think are down to two.

**MR JONES:** Two.

**DR COOKE:** Right, okay. You're also going to be covering those children who are in the custody of the Chief Executive but who are placed in care, aren't you, with some other contracted provider, who provides -- there may be a care contract, but they don't have custodial status.

**MR JONES:** At the moment those tamariki are in scope because they are in care, they are in the care of the Chief Executive of Oranga Tamariki, but they are placed with a shared care

provider. So as part of our monitoring we meet with those shared care providers and we talk to them about how care is being delivered.

**DR COOKE:** If you took the example of Barnardos, who have two children for whom have status, but they would have a large number of children who are in their care under a care contract.

**MR JONES:** That's correct.

**DR COOKE:** Do you go and talk directly to Barnardos or do you do the talking with Oranga Tamariki.

**MR JONES:** No, with the provider of the services, as well as Oranga Tamariki.

**DR COOKE:** When it comes to monitoring, is that a checking that the paperwork is in place, ie that they've got a correct manual and the manual's got all the subparagraphs correct, etc, or is it more than that?

**MR JONES:** It's more than that. You can't expect the monitoring to be robust if you're just relying on data points like that. That's why we have that balanced model of both receiving the data, are plans in place, how frequent do social workers visit tamariki in care, but also why we invest so much of our effort into meeting with communities and talking to them about the experience. It's one thing to say you may have a plan, it's another one to say does that plan meet your needs and are you getting the services that that plan sets out. So you need to do both.

So this is the marrying up of conversations, practical experience, lived experience, with data, because both are important, bringing them together and telling a story.

**DR COOKE:** So when you go out into the communities, are you going out into, because there are a wide variety of communities that we can talk about here, do you go out into the community, for example, and speak with caregivers of children who are placed, as one example?

**MR JONES:** Yes, yes.

**DR COOKE:** Do you go and speak with whānau of children who have been taken from them and are placed in care or have been placed in care?

**MR JONES:** Yes, that's correct.

**DR COOKE:** And who else do you see? Do you talk to the iwi providers, the -- because I think I saw that you've got 12, I think it said in your paper that you've got -- you're engaged with 12 organisations.

**MR JONES:** No.

**DR COOKE:** Have I missed the plot there.

**MR JONES:** Maybe. I think there are the strategic partner, iwi and Māori providers that have strategic arrangements or partnerships with Oranga Tamariki, monitoring of those arrangements is future work under the Bill. I might give an example.

So our most recent visit into the community was into the Bay of Plenty and the approach we take, we don't just contact tamariki and rangatahi, what we do to make sure their engagement meets with those young people in the right way, we work through connectors. So, for example, in the Bay of Plenty we worked with Ngāti Awa, Tūmanako Trust key assets, Hapū Ora, Te Kokiri Trust, Raukawa Iwi Services, Manaaki Ora, Whakaatu Whanaunga Trust and the Tauranga Women's Refuge as partners to help us connect with whānau and with caregivers and with tamariki, so they can be there. Because they know these kids and they know these families and they can support them in the conversations with them so that you're not having a stranger-to-stranger conversation. And that is so important for the way that we work, so that we can have careful conversations at the right time and in the right place.

So I think in answer to your question, we take what was asked of us from those initial hui way back in 2019, is that we take a 360 degree view of care and we've been very careful to make sure that we try and, with resources, meet with everybody that is close to those lives of tamariki to get their views.

**DR COOKE:** Just going back, just to be reassured, I suppose, on a question I asked earlier, is that there are no, in terms of your programme to, get out there and engage with family whānau at all levels, you do not foresee any budgetary constraints that would inhibit your work in that regard?

**MR JONES:** No, and as we plan to commence that work, if there were any, then I'd be having a conversation with the Minister.

**DR COOKE:** With the Minister, yes, that's looking forward to the next stage in life.

**MR JONES:** Yes.

**DR COOKE:** Right, okay. Going out there, my friend Mr McCarthy asked some questions of your colleague earlier around making sure that those who work, you, those who work with you, have the -- are qualified in the broadest possible way so that you know what you're talking about when it comes to Te Tiriti, you are able to appreciate and understand, making sure that tikanga is being honoured in real terms. Tell us about those aspects of the work you're doing and how you're complying yourself with those matters.

**MR JONES:** Since we were first established in 2019, we've focused on building a strong tikanga foundation. We have engaged with iwi, Māori and community partners from across the

country. We have a Kahui group that keeps me and my team honest and that is made up of Māori rangatira. And I rely on their advice and expert guidance.

We have been very purposeful in our recruitment, I'm very proud of the fact that we have 50% of our kaimahi whakapapa Māori that are doing the monitoring. And if you have the chance to look at our kawa and our tikanga, it's all on our website, it has been developed very much with a Te Ao Māori lens.

I think it's really important, and those that have worked with us in communities will know how it feels when kaimahi from the monitor come out and meet with them. And I have every confidence that we are doing this work in the right way.

But also we have our ears and are ready and particularly with Te Kahui to tell us if we are making a misstep.

**DR COOKE:** Is that an interactive website?

**MR JONES:** Interactive? You can find -- I don't know.

**DR COOKE:** What I mean is, can people, could I or could a rangatahi in the Bay of Plenty for example get on to your website and say, "This looks really good" or "I have a question here", can they interact with you in that way?

**MR JONES:** So could they contact us?

**DR COOKE:** In a meaningful way, is what I'm getting at.

**MR JONES:** You can use that website to contact us, it's pretty old school in terms of e-mail, and people do, and we will hope to answer their questions. And people are starting to say, "Please come and speak with me when you are in our community", so that's certainly an invitation there for folk.

**DR COOKE:** I wanted to finish just with your report and the comments around Oranga Tamariki. I think if probably BAR 000720-10 is the document. We'll keep that there but before we go, before I start on that, I won't go into the detail around the outcomes, but certainly the summary would be that Oranga Tamariki in its compliance to the outsider would appear to be struggling in many respects. Would you think that that is a fair summary of an outsider who is reading, would be reading your report?

**MR JONES:** I think in reading the report there are areas where their performance is strong and there are certainly areas where it is not.

**DR COOKE:** I saw a Radio New Zealand headline the other day which talked about "Abuse in care is greater now than it was in 2018", something along those lines. Because the numbers were higher. Now, that could be explained because the age of leaving has gone up or whatever, remember the age went from --

**MR JONES:** There could be a range of reasons.

**DR COOKE:** A range of reasons. Because one of the concerns has always been that the number -- that children in care, the numbers who are abused, hurt, neglected, is at a -- first of all, it shouldn't occur and secondly, despite everything we know, it is still occurring. So we know that, don't we.

**MR JONES:** That's correct.

**DR COOKE:** As for Oranga Tamariki, and if we could highlight here's the second-to-last and last paragraphs, so the first paragraph comments in relation to health services that Oranga Tamariki can't report on that, that's a pretty big area, isn't it.

**MR JONES:** Yes.

**DR COOKE:** And they can't comment as well on whether caregivers are given appropriate training and information about the tamariki they care for, and that's another big area.

**MR JONES:** Yes.

**DR COOKE:** Given the number of children that are in care and who have to go into alternative care arrangements, not being told that the child who's coming into your care may have all sorts of behaviour issues could be problematic.

**MR JONES:** Agree, and that's why the care standards require -- this is one of the standards that needs to be met, yes.

**DR COOKE:** And this is one of the standards that would appear caregivers are saying, "We're having trouble around this."

**MR JONES:** Yeah, I think this is one thing, there's Oranga Tamariki's data systems and their ability to provide answers to show compliance with those care standards. The other part obviously is the conversations that we have with tamariki that help verify whether the information that we are provided with is accurate, and what you see in this report is that the data that we do have is backed up with the conversations that we have with caregivers and with tamariki.

**DR COOKE:** It still begs the question, doesn't it, and I tried to pose this question earlier on, that there has to be doubt about the capacity of Oranga Tamariki in being able to meet the care standards -- its care standards which it put in place as from 2019 but which were a work in progress for some years before then. One would think that they would have had ample time over that -- those period of years to make sure that their systems were in fact in place and ready to go and so by the time of your most recent report, you would not be saying, as you do in the last paragraph, that --

**MR JONES:** Those care standards require agencies to have self-monitoring and assurance practices of their own. And yes, I am concerned that they don't yet have them.

**DR COOKE:** That last paragraph is a fairly strong one, isn't it.

**MR JONES:** That's correct.

**DR COOKE:** The lack of data means that you cannot provide the required level of assurance across the care system. You cannot say whether tamariki and rangatahi in care are getting what they need. You cannot say if they are therefore better off because of the regulations. It hampers our ability and that of OT to gain insights into what would help improve the quality of care.

If you look at -- you cannot say that children are better off because of the care regulations, when that's the very purpose of those care regulations, is to make life for them better off and for that to be perceivable.

**MR JONES:** Although, Mr Cooke, what I would say is there's an old adage which is "what gets measured gets done", and now that we are reporting on these care standards and the compliance, it is my hope that we see an improvement in compliance with those standards, and that is the purpose of why the monitor is here, to provide that transparency.

**CHAIR:** Thank you, Dr Cooke.

I'm just going to check with our signers and our stenographer, have you got 10 minutes more in you? Thank you very much.

I'm just going to ask our fellow Commissioners if they have any questions for any of the three witnesses, I haven't asked you if you've got the stamina, but you're there and you can't escape until we say so I'm afraid -- but we'll see if there are any questions for you.

**COMMISSIONER GIBSON:** Kia ora, my question is for Ms Power. Looking at the breadth of MSD's responsibility historically and into the future, moving aside from children at the moment, vulnerable adults have been in the care of MSD or have been contracted outside through sheltered workshops, day services, it hasn't been a big focus but what's been learned historically, we have heard through private sessions, abuse in these places, what's been learned historically about the care of vulnerable adults and MSD funded services and then what are the lessons going forward?

**MS POWER:** I think we certainly acknowledge that the care hasn't been of the standards that we would expected today, or even in the past, to be honest. I think what you've heard today from both Barry and from Arran and from the responsibilities that CEs have in terms of contracting out services is that we need a robust accreditation process, we need people to be monitored in terms of the services that they provide, we need appropriate mechanisms for

people to raise concerns and we need to act, and we need to take action and we need to ensure that we follow up.

So one of the things that we must make sure is that when allegations are made that we follow up and that we close the loop on the people who have made that allegations to ensure that they're part of that process.

**COMMISSIONER GIBSON:** Just thinking about the vulnerability of this group and what we learned through the disability mental health hearing and the struggles to report, also reflecting in the comment in the evidence and on the response to the Notice to Produce about ableism and -- there wasn't a response from the Ministry itself, it was -- the operational part had been delegated to OT, but there is a role for the Ministry around understanding ableism and the impact it has in terms of policy, contracting or whatever, and being able to respond to the needs of this group of people who are indirectly within provision of MSD.

**MS POWER:** I couldn't agree more, I think what we've also seen is the establishment of the new Ministry for disabled people and the remit that they will have to provide advice and advocacy to ensure that agencies make sure that people understand those issues, and that we have processes and practices in place.

So I see that as a positive thing, that elevates the importance of this group of people who have often found it difficult to engage, difficult to raise issues, difficult to access services and get their voices and perspectives heard.

**COMMISSIONER GIBSON:** The counsel for the Crown in opening talked about the acknowledgment in the past of people in day services doing almost nothing and adults not being paid adequately. Do you see that as ableism and does that still occur in MSD-funded services today? To what degree are you confident about these things?

**MS POWER:** I still think there is some outstanding issues that are part of processes that need to be resolved in terms of the way in which we remunerate people and what that means, that's still a question that is outstanding. But in terms of making sure that we value the contribution of people and that they are safe and secure in whatever programmes they participate in, I certainly agree that that needs to be front and centre.

**COMMISSIONER GIBSON:** Thanks.

**COMMISSIONER ALOFIVAE:** Thank you, can I just pick up where Mr Cooke just left off with Mr Jones and so just to use the example, Mr Jones, that was in your report around the education. So you can measure enrolment, or -- as an indicator?

**MR JONES:** Yeah.

**COMMISSIONER ALOFIVAE:** But actually the responsibility lies with the Minister of Education as to the regularity of attendance and the quality of education, and so out of that it really speaks about the quality of the educational component of the life of the young person, so we've got that, I just want to park that. Then I look at your outcomes framework, I'm just looking at the one-pager that you have on your website. And I'm going down to your goal of mātauranga, and I think your top indicator there is the only indicator where it might fit, tamariki and rangatahi are engaged in learning and meaningful daily activities.

So I appreciate that there's probably a much bigger exercise behind this and this is all you can fit on the one page, so I do accept that, but in terms of being able to make connections and draw the thread around the quality of the journey of the young person in care, that really speaks to the how, right? How do you do integrated services better? Because you could make the same comment about a health issue, social service provision, about housing.

So I was interested in your comment that you don't make recommendations, yet the monitor is well positioned to see some very big themes come through in your different localities, in your regions but also nationally. Do you want to respond to that, are you able to comment on that?

**MR JONES:** Yeah, I think you're right, as we meet and speak with more people in the system, if you use that word, I don't really like it but you know what I mean, we've got a very robust way of understanding and theming their experiences, so we've built in quite a database of these conversations so we can see where people are speaking to barriers against each of these outcomes. So, for example, in mātauranga, tamariki may be saying to us "School's not good for me" or "education's not good for me", and then in our conversations with them we might be asking "So what is it that is not right?" And that could be "The teachers don't relate to me", it might be "Actually, it's really difficult for me to get to school because I need to catch a bus, I need this and I don't always have the money and I don't know how to ask for it to get there", so there could be practical reasons.

So when we look at each of those outcomes we're trying to understand the root cause that's getting in the way of the outcome being achieved. That's why -- I talked before about because it's a complex system there'll be a range of things but what we will do over time is start to see those themes coming up and that's what will generate insights. So it will become a clear insight that in a particular -- it may be just in a community but it may be nationally that there's a real issue for tamariki to be able to get to school. I'm just saying it

could be something, right? And that becomes an insight. And then the question is on agencies, so what are you doing to help to make sure that those kids can get to school easily?

It's probably not the best example but I'm just trying to paint a picture of how it operates in practice.

**COMMISSIONER ALOFIVAE:** I think it's a good example of a micro --

**MR JONES:** It is a very micro, yeah.

**COMMISSIONER ALOFIVAE:** -- which is part of a bigger macro which then leads me to my question for Ms Power.

So you'd be fully appraised that abuse and neglect in care is not a new issue, that previous administrations have grappled with this issue, and it seems that now ministries like yours, because it's such a big shop, are being asked to do more and more and it's about understanding your core business and the role that your Ministry plays in a bigger universe -- it's a word I often use to kind of describe the system.

And when you see these themes that are coming through in your own ecosystem within MSD and all of the bits that you talked about that as the CE you're responsible for, do you think a possible solution or maybe an avenue might be to look at agencies' accountability documents, so the statement of intent and the statement of performance and expectation, and actually that that might be a vehicle across agencies to be able to hold each other accountable, so that when examples like what Mr Jones has raised, actually there is a collective scorecard of some sort where we can -- where successive agencies, you know, can say, we've known about that issue, like the abuse issues, and this is how we've tackled it across agencies as a mandate.

I'm just -- it's just something that's really coming to the fore out of the discussion that's been generated this afternoon.

**MS POWER:** Thank you for that question. You're absolutely right that I think being able to look at the different roles that agencies play and how that impacts on individuals and their families and their communities is really important, and we've often for a long time talked about siloed approaches etc, etc. I do think and, you know, Arran's talked about this today, but I do think that there is a growing appreciation that if you want to deliver services to or with people in communities, it is best done in a place based, however, you describe that; so I'm not precious about that, but with people who understand the context in which the community operates and the services are needed with people and relationships that are built on trust that really put those families or those individuals at the centre, and being able to

demonstrate agencies' contribution to that and be agile and flexible in the way in which we fund.

So I absolutely understand the need to make sure programmes are delivered with integrity and appropriately, but they also need to be adjusted for the context in which they are delivered, and I think there's an increasing view that that is the way with which to do that, and it enables agencies to kind of work with trusted partners and kind of at one level get out of the way because it doesn't have to be delivered by an agency all of the time.

**MR JONES:** Yeah, and to add to that, what we've seen from visits is actually the success in collaboration between agencies or between NGOs and Government lies in relationships, and extraordinary individuals doing fantastic work. That's why you can make recommendations around systems or things when actually at the heart of it is often people, and so it's about how -- I think what Debbie was saying, sometimes it's about how perhaps the State can be a follower rather than a leader, and actually support what is there. And I guess this speaks back to my point about the risk of making recommendations, because it's actually local conditions and local solutions.

**COMMISSIONER ALOFIVAE:** Thank you, no further questions.

**COMMISSIONER ERUETI:** Hi, Mr Jones, you could keep going, please. It just seems rather complicated having, I know you talked about the merits of having the three and how you all talk to one another. Just even describing that, about how your function of gathering the data is split from the sort of advisory recommendatory function which will be with -- it seems with the Office of the Children's Commission but I'm not -- how would it be for a child or whānau? Where will they know where to -- how will they navigate the system if these different functions are not -- it's not really clear where they are allocated or why they are separated in this way?

**MR JONES:** Yeah, I can't speak in terms of the clarity of it for tamariki and rangatahi. I think there is -- look, it's swings and roundabouts and there are advantages in the various approaches and systems. I think what's important for the three agencies is to be very clear and open and communicate well in terms of what it is that we do. In some ways what's contained in the Bill almost simplifies things in the sense that we have clear responsibility between the three agencies whereas before, if you look at issue of the uplift of pēpē in Hawke's Bay, there you had the Children's Commissioner producing a report, you also had the Ombudsman completing their investigation, and for me, we want to make the best use of the resources that we have available. And I think the three of us working together can do -- I have every confidence that we can do that.

And so when I talk to the Children's Commissioner she says, "Okay, so every year, monitor, you're going to produce this report on the care standards". And she says, "I'm going to read that closely", and this is what she will take to do her advocacy work.

So the proof will be in the pudding but I have confidence that we can make this work.

Also, between us if we get -- it's an open door approach from all three of us, so if rangatahi were to contact us or caregivers or whānau seeking assistance, then we can handshake them to the right part of the oversight system. This has already happened. So we've had complaints raised with our kaimahi doing the monitoring and we've managed to make sure that they connect up with the Office of the Ombudsman, we check back with their whānau to make sure they are connected and their complaint is being handled. So it's about the three of us co-operating and working together.

**COMMISSIONER ERUETI:** There's nothing in the Bill that says that you can't provide advice or recommendations, right? That's something you've just imposed upon yourself?

**MR JONES:** No, the Bill sets out what is required but that's not to say there aren't other aspects that we could do. We're going to learn about this as we go. This is a new function, albeit the Children's Commission had that ability too, but this is the first time that we have a properly resourced monitoring function in New Zealand and it's almost novel in the world in the way that we do this. And so the legislation, it's got a review period in three years' time to come back and see how is this operating.

**COMMISSIONER ERUETI:** Yeah, okay, thank you. The other question I have is whether you have -- I'm only going to ask one more question because of the time -- is whether there is scope, you see any scope within the monitor to bring Māori into the governance table. So the Office of the Children's Commission appointed an assistant commissioner, now they will, under this Bill, they have a board which provides another voice at the table, and I acknowledge what you say about your advisory group and among them the rangatira of advisors, but it's not the same thing as having someone at the table.

So there is that, you know, 60% of Māori in care, you're going to monitor not only the National Care Standards but also Section 7AA of Oranga Tamariki which is giving effect to the Te Tiriti responsibilities. There's already this perception of lacking independence; how are you going to generate trust in the monitor if you don't have representation at that governance level?

**MR JONES:** Well, you know, there'll be a process for appointing a Chief Executive. That Chief Executive could well be Māori. The other part to this is that when we think about the

monitoring of Section 7AA, I'm being very mindful of not telling stories for others. I want them to tell their own story.

So if we think about the monitoring of those strategic partnerships that Oranga Tamariki have with iwi and with Māori providers, we are starting to think about how best to do that. I'm very mindful of, actually, this is not the monitor's story so much to tell, this is an opportunity for the providers to tell their story as it is for Oranga Tamariki and perhaps for us to move out of the way of that. I think that's an important facet to it and we can support the telling of that story.

So the Bill proposes that we can enter into information sharing arrangements with iwi and Māori providers and so we have started to have conversations about, "Well, if we can get this information, would you be interested in it to help you tell your story?" So I think that's a way that we can work to our obligations under the Treaty.

At the same time we do need to make sure we have the competence and the capability within the monitor to be able to do this monitoring as well. And so that is going to be part of our journey.

We already work closely with te Kahui, we meet with them every month, we now need to start thinking about the Māori advisory group and how that will function.

But I do take on your point, I'm very mindful of it, and it will be part of our journey.

**COMMISSIONER ERUETI:** Kia ora, thank you, thank you for your answer.

**COMMISSIONER STEENSON:** Tēnā koutou, I'm mindful that I'm dragging the chain here a little bit, so I had questions for all of you but I will slim it right back. And I am going to ask you, Mr Jones, some questions, I think, I've decided out of my questions.

It is around the scope of the care system and what that entails.

**MR JONES:** There are two bits, so there's the current scope under the care standards and like I said, there's -- we try to look at everything that goes into supporting the lives of tamariki that are in care. So that is why we hold hui with representatives from the Ministry of Education and communities alongside representatives from the Ministry of Health, from Police, we have people from schools, so we're interested in anybody that delivers services -- services, ie support, to tamariki that are in care.

**COMMISSIONER STEENSON:** Does it include their whānau? Is it whānau-centric?

**MR JONES:** Yes, yes, certainly. So I probably mentioned since January '21 we've met with 70 whānau, it's certainly an area where we want to do more. It's probably the most challenging of the groups to engage and connect with.

We are about to visit South Auckland and I'm very pleased we will be also visiting a prison to meet with whānau that have tamariki in care and speak with them and about their experiences. So it's certainly something that we have a strong focus on. And that's re-enforced by our te Kahui members to make sure we are engaging and speaking with whānau.

**COMMISSIONER STEENSON:** Does it cover things as far as things like housing, because I've heard from providers, service providers that it's hard to get in touch with whānau because a lot of them are homeless and they're living in their cars, for example.

**MR JONES:** I think this comes into the second part once we start to monitor and report on the whole of the Oranga Tamariki system. And so not only are we looking at tamariki where there may be a report of concern, so they're at risk of coming into care, and we will be looking at how are the services working for them so that whānau can be supported to keep those kids safe in their care without them having to come into the State care. And that includes the provision of housing support, you know, because like I said, you know, tamariki should be coming into care where it's going to be for their benefit, their lives should improve, but equally there should be opportunities and we should be looking at what are the opportunities to support whānau so those kids don't have to and they can have their best lives with whānau, and if that means healthy safe housing then that's something we'd be looking at.

**COMMISSIONER STEENSON:** Okay, so do you also cover, does the scope include faith-based care providers?

**MR JONES:** No, not under the -- they don't fall within the care standards, unless those kids are actually in -- the tamariki are actually in their legal guardianship and custody.

**COMMISSIONER STEENSON:** Right, and so is there no monitoring under those guises?

**MR JONES:** I think yeah, it might be in terms of us considering, it might be something to consider in terms of monitoring the whole of the Oranga Tamariki system and seeing where they fit in there. I might need to come back and perhaps provide you with an answer to that later if that's okay.

**COMMISSIONER STEENSON:** That would be great, thank you.

Then also, what about vulnerable adults, so yeah, I mean up to 25 you've been talking about, but we know that there are those tamariki with neuro diversity, other disabilities who actually have it for their life time, so I'm just curious to know how far that scope is.

**MR JONES:** Yeah, it is just to the age of 25. So that is the extent of our mandate. But obviously, you know, making sure that they have the services they need to give them the opportunities, but we can't follow them into adulthood.

**COMMISSIONER STEENSON:** Thank you. And then, I'll make this my last question for you. Data. I'm a advocate for data, so it's great to hear that that's one of your priorities, because it's been sorely lacking, and the way that you are gathering it from qualitative and quantitative methods. But I am a little bit surprised, as my fellow Commissioner was, around reserving recommendations, because I wonder whether if you're just a data provider that's something that Statistics New Zealand does. What's the difference here?

**MR JONES:** Okay. I wouldn't describe us as just a data provider, it's about actually differing insights. So when we are going into communities we take an approach of looking at system elements as to what is causing or resulting in success and what is proving a barrier to success, and trying to understand the root causes around why something is happening.

So, for example, visiting one community, iwi provider explained they had difficulty forming relationships or strong relationships with Oranga Tamariki social workers. And then when you start to dig into that, the answers are, and it's not, you don't have to dig too far but it's to do with the turnover of staff, and so then the question is what's causing the high turnover of staff, because until you can fix that, you're not going to get the relationships that are going to enable the system to operate as effectively as it can.

So those are some of the insights that we hope to be able to provide, which is much more than just data.

The other part on the data story is, I think, the story for tamariki in care or for tamariki at risk of care, is not always seen in existing datasets. So part of my drive is to be able to get visibility of these tamariki, these rangatahi in those datasets, and then seeing if there's a gap and, you know, we all know that there will be, is it closing and being very transparent about that, because again, as I said, what gets measured can often be the thing that gets done, and by being able to highlight the fact that work is required and tracking to see whether improvement is happening, that's where I hope that we can influence the system for the better.

**COMMISSIONER STEENSON:** Okay, so through the data, which nobody argues with, is great.

**MR JONES:** Yeah.

**COMMISSIONER STEENSON:** Then the "then what" and then the monitoring of no change, I guess the worry is, what happens if there's no change just with monitoring? Is there a point where you say actually something needs to be done?

**MR JONES:** This is, I think I mentioned about reserving the use of recommendations. Issuing large numbers of recommendations I don't think would be helpful, but we reserve the right to do it when we need it. What I would be looking for is that accountability through the ministers to their agencies to saying, "Look, the monitor is reporting that yet again this has not improved. What are you doing to make things better? Because we know the monitor will be there again next year to see whether things have changed."

**COMMISSIONER STEENSON:** Thank you, tēnā koe.

**CHAIR:** That leaves it for me. I had one question and it's directly on that point, I want to ask it really to Ms Power, I think, although you're all welcome to chime in, and it is about accountability. We've heard about the three branches, the Ombudsman, the Children's Commissioner, and the independent monitor. And on your account each of them is going to be doing as best they can to hear complaints from tamariki, hear the reports, get the data together, make the recommendations. The Children's Commission will do advocacy and the like.

So a major picture will be built up and at this stage, based on the independent Children's Commissioner monitor now it's still not a rosy picture. My question is, and I do this on behalf of all survivors, where ultimately does the accountability lie? Because there's been precious little demonstrated to date.

So people are working away, we referred to silos, Ms Power, and we all know about that, we know people are breaking it down, but where will the accountability lie? Where will the receiving house for all of this be, where will be the single entity, body, person, God-like figure if you like, who is going to take this and say, "This is wrong, this needs to be changed." Or, "This is wrong, and this person needs to be responsible"?

**MS POWER:** I think if we're talking about children in care, the State agency responsible for children in care, the care of those children is currently the agency called Oranga Tamariki, that would be my answer. In relation to ensuring that children in care get the services and support that they need and that the system is monitored sufficiently to ensure that and play that back into the system, I would say it's the independent oversight functions which yes, is currently split between the three.

And I do think that the Children's Commissioner being able to advocate for all children in New Zealand and provide that advocacy function is important. I think the monitor's ability to be able to monitor and go about the monitoring function in the way that they've proposed is important, and I think the Ombudsman's ability to investigate is absolutely necessary in the system. And it is about those three functions working together

to ensure that those insights and actions get played back into the system and hold both the agency of State, who has the ultimate care of the children, and others, including myself, in terms of to be held to account is the answer. It's not -- it isn't as straightforward as we might like it necessarily to be, but that is the system that I see.

And particularly making sure that we are providing the services and support to children in care who are the most vulnerable in New Zealand, whether it be health or education or social services is absolutely the right question.

**CHAIR:** I think survivors might say this is all well and good but what's happening is it's feeding back in on itself. Oranga Tamariki is responsible, it's being told that it's not -- this is hypothetical -- it's being told it's not working, things are wrong, complaints are being made, what if it doesn't change, because we have heard generations upon generations of reports saying change, change, change and nothing has changed or not enough has changed. How do we know that this is going to be different?

**MS POWER:** I'm not going to sit here and say there is the silver bullet and we can expect a miracle to happen, because as you have said, we have got many survivors whose experience of the system has been very different and I do absolutely want to acknowledge that.

What I would say is that our focus has to be on those children and ensuring that they get the services and support that they need, and that there is an oversight function that can help do that, all who report directly to ministers, and so I think there is that accountability line, and we just -- and we do need to do better and we need to be held to account, whether it be through these processes, or others, to make sure where we have not done what we say we're going to do there is a consequence.

**CHAIR:** Thank you. Thank you for that. We are well over time, but that's not a criticism, that is a recognition of the big, hugeness of this issue that I know -- I'm sure that counsel would like to have had each of you for a good full day each and that's not possible, I'm sure you're glad they couldn't. But the fact we've gone over is a demonstration of the importance of this topic.

Can I thank you each individually and for your organisations because I'm conscious and everyone's referred to it, a vast amount of work has been done by your teams to respond to the numbers of Section 20 notices we've sent out, we're conscious of that and you've prepared your briefs of evidence and we're grateful for that and we're very grateful for your appearance today. So thank you very much indeed.

Kua mutu aku mahi i tēnei wā. I'm not really looking at you, Ms Beaton, unless you really wanted to say something, I'm looking beyond you to our kaikarakia.

**MS BEATON:** I was just going to say, ma'am that, we're reconvening at 9.45 tomorrow.

**CHAIR:** 9.45 we will commence tomorrow. Tēnā koe matua, kei a koe te tikanga.

**Hearing adjourned at 5.48 pm to Tuesday, 16 August 2022 at 9.45 am**