Under The Inquiries Act 2013

In the matter of the Royal Commission into Historical Abuse in State Care and in the Care of Faith-based Institutions

Brief of evidence of Philip Blair Knipe on behalf of the Ministry of Health – Redress

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1 Introduction

1.1 My full name is Philip Blair Knipe.

1.2 I am employed as the Chief Legal Advisor at the Ministry of Health (the **Ministry**). I have held this role since joining the Ministry in January 2008.

1.3 I am responsible for the provision of legal services to the Ministry and management of Health Legal, the Ministry's in-house legal team. I am also responsible for the Ministry's Knowledge Services – Library and Records.

1.4 As part of my role, I am responsible for overseeing and processing claims of abuse received by the Ministry relating to events occurring in public healthcare prior to 1993. This has largely involved claims of physical and sexual abuse in the context of treatment in state-run psychiatric hospitals, but it has also involved claims arising in the course of attendance at psychopaedic facilities (such as Mangere, Kimberley and Templeton). I have been responsible for processing these types of claims since the Ministry assumed responsibility for them in July 2012. Prior to that, I was the Ministry's representative on the Historic Claims Inter-Agency Working Group.

1.5 This brief of evidence includes an explanation of the following:

(a) How the Ministry has received, processed, managed and conducted its strategies in relation to redress for civil claims (monetary and non-monetary) made or filed between 1 January 1950 and 30 August 2019 (the **relevant period**).

(b) The criteria under which survivors were eligible for and able to receive monetary redress for civil claims made or filed during the relevant timeframe, how such monetary amounts were calculated, and the means by which such information was made available to survivors and/or their legal representatives.

(c) The extent to which the Ministry's policies, procedures, processes or strategies had regard to Te Tiriti o Waitangi and tikanga Māori.

(d) The approach to, use, or application of legislative provisions, including but not limited to the Limitation Act 1950 (and the subsequent Limitation Act 2010), the Privacy Act 1993, the Official Information Act 1982, and the Accident Compensation Act 1972 (and successive legislation), including whether and, if so, how legislative provisions hindered or precluded the ability of individuals to bring or pursue civil claims against the Ministry.

(e) The means of resolution or settlement and outcomes (monetary and non-monetary) of all civil claims within the relevant timeframe.

(f) The total cost to the Ministry of all monetary settlements for civil claims made or filed during the relevant timeframe, and the total expenditure by the Ministry on litigation costs in the same period.

1.6 I do not propose to address the process for managing claims made concerning abuse occurring in the context of public healthcare **after** 1993 because legal

liability for these claims lies with District Health Boards (**DHBs**) (and not the Ministry).

1.7 In my view, the history of the process for addressing claims of abuse arising in the context of public healthcare is divided into four distinct periods of time:

Regional service providers

(a) Prior to 1993 various iterations of regional service providers followed their own practices and processes when receiving complaints or claims of abuse, but there is very limited information available to the Ministry about these processes because the entities that dealt with these matters were separate from the Ministry (and its predecessor, the Department of Health).

1992-1996 - Philosophical system change

(b) Between about 1992 and 1996 the public healthcare system significantly changed its structure and care philosophy in a way which shifted the previous practice of bringing patients into state residential care or custody for treatment towards greater community-based care options, with greater recognition of patient rights.

Growing number of claims against the state

(c) From the late 1990s onwards the central health government agency known as the Crown Health Financing Agency (**CHFA**) started to receive increasing numbers of historic claims of abuse in public healthcare which were dealt with by litigation or settlement processes. This resulted in the set up of various forums to hear claims and offer assistance. In mid-2012, a large scale settlement of court proceedings that had been lodged and foreshadowed occurred.

July 2012 – Present

(d) The Ministry assumed responsibility from CHFA for historic abuse claims relating to Area Health Boards, and their predecessors, and established a Historic Abuse Resolution Service (**HARS**) administered by the Ministry. This remains the current mechanism for receipt and redress of historic claims of abuse occurring before 1993 in public healthcare.

2 Regional service providers

2.1 Between 1950 and 1993, the structure of the New Zealand public healthcare system comprised individual regional service providers (the predecessors of DHBs) which each determined their own practices and policies in relation to addressing claims of abuse occurring in the public healthcare system.

(a) By 1950 a number of psychiatric institutions had already been established for the detention of mental health patients under the Mental Health Act 1911;

(b) In 1957, 29 Hospital Boards were established under the Hospitals Act 1957;

(c) Between 1983 and 1993, 14 Area Health Boards were established, replacing the Hospital Boards as well as receiving devolved responsibilities from the Department of Health.

2.2 During this period of time, neither the Ministry nor its predecessor, the Department of Health, were responsible for addressing claims of abuse.[1] As a result, the Ministry does not hold information on how these various bodies historically addressed complaints or claims. My understanding is that each Area Health Board (and its predecessors) had its own processes.

2.3 The Ministry is not aware of any systematic response to claims of abuse from this time. However, I understand that mechanisms for investigations and inquiries did exist. This is evidenced by a range of reports into mental health services that were commissioned throughout the period. These include the 1971 Report of the Commission of Inquiry into Psychiatric Services at Oakley Hospital, which was produced pursuant to the Commissions of Inquiries Act 1908, and the 1988 "Mason report", which was produced pursuant to the Hospitals Act 1957, the Area Health Boards Act 1983, and the Commissions of Inquiry Act 1908.

2.4 In the circumstances, I am unable to provide any information about practices and policies for addressing claims of abuse during that time. However, I will address the important changes that occurred in the early to mid 1990s.

3 1992 to 1996 – Philosophical system change

A new care philosophy

3.1 On 1 November 1992, the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**Mental Health Act 1992**) was enacted. This Act represented a significant cultural shift to community-based care of mental health patients, away from caring for patients long term in residential psychiatric institutions. Its emphasis is upon consideration of the need for treatment and the provision of treatment in the least restrictive environment.

3.2 The Mental Health Act 1992 expressly provides for patients' rights (see for example Part 6 of the Mental Health Act 1992) and established avenues for access to complaints mechanisms such as:

(a) Referral of complaints to district inspectors who have powers of investigation and who can make recommendations to the Director of Area Mental Health Services. The Director must take all steps to remedy the matter (sees 75 of the Act).

(b) A secondary complaint mechanism is an inquiry under section 95 of the Mental Health Act 1992. This is used when multiple issues indicate possible systemic problems. Terms of Reference are established by the Director of Mental Health and the inquiry is undertaken by a district

[1] With the exception of Lake Alice, which I understand the Ministry had responsibility for until its transfer to Good Health Wanganui in 1993. No specific redress process for claims, other than the usual processes in accordance with Mental Health legislation has been identified until the commencement of the Lake Alice settlement process in 2001.

inspector who has the powers of a Commission of Inquiry while undertaking the work.

(c) The Mental Health Review Tribunal, an independent body appointed by the Minister of Health whose activities include:

(i) deciding whether patients are fit to be released from compulsory status;

(ii) making recommendations about the status of special patients;

(iii) considering the status of restricted patients;

(iv) investigating complaints about breaches of patient rights where a complainant is not satisfied with the outcome of a district inspector's investigation;

(v) appointing the psychiatrists who give second opinions about patient treatment; and

(vi) appointing the psychiatrists who decide whether electro-convulsive treatment is in the interests of patients.

(see Part 7 of the Mental Health Act 1992).

(d) A High Court Judicial inquiry process to establish whether an inpatient subject to a compulsory treatment order is fit to be discharged (s 84 of the Mental Health Act 1992).

3.3 This was a significant move away from earlier mental health legislation, which significantly restricted a patient's ability to raise complaints about treatment and matters relating to that care.

(a) Section 131(1) of the Mental Health Act 1911 provided that "[a] person who does any act in pursuance or intended pursuance of any of the provisions of this Act" was not under any civil or criminal liability "if he has acted in good faith and with reasonable care". The Court was given power to stay proceedings brought in respect of any such act if satisfied that there was no reasonable ground for alleging want of good faith or reasonable care, or that the proceedings were frivolous or vexatious (s 131(3) of the Mental Health Act 1911). As well, there was a six month limitation period for bringing such actions (s 131(4)).

(b) In 1935 an amendment to the 1911 Act repealed the stay provision (s 6 of the Mental Health Amendment Act 1935). In its place, s 6 of the Mental Health Amendment Act 1935 imposed a requirement that leave be obtained before any person commenced such a proceeding. Following that, a patient wishing to bring a proceeding against a person who was acting under mental health legislation first had to satisfy a judge that there were substantial grounds for the contentions made before being able to commence proceedings. Section 6 continued to apply until the repeal of the 1911 Act in 1969. It was replaced by s 124 of the 1969 Act, which was on substantially the same terms.

3.4 Relevant to rights of those in public health state care, in 1990, approximately two years prior to the enactment of the Mental Health Act 1992, the New Zealand Bill of Rights Act 1990 came into force. It includes a variety of rights relevant to health treatment, including the right not to be subjected to torture or cruel treatment (s 9), the right not to be subjected to medical or scientific experimentation (s 10) and the right to refuse to undergo medical treatment (s 11).

3.5 From 1993, a number of important structural changes occurred in the New Zealand public health sector. These began the development of the modern healthcare system that operates today. The changes included the following:

(a) The establishment of Regional Health Authorities (**RHAs**) and Crown Health Enterprises (**CHEs**), replacing the former Area Health Boards. RHAs were established as the purchasers of healthcare, while CHEs were established as providers of healthcare.

(b) The establishment of the Residual Health Management Unit (later renamed the Crown Health Financing Agency (**CHFA**) in 2000) which assumed responsibility for remaining Area Health Board assets and liabilities which had not been transferred to RHAs or CHEs. These liabilities included responsibility for any historic abuse claims relating to Area Health Boards and their predecessors.

(c) The Ministry was established in 1993 as a streamlined version of the Department of Health.

3.6 Between 1994 and 1996, statutory protections for users of health services (including mental health services) were introduced in New Zealand with the establishment of the role of the Health and Disability Commissioner in the Health and Disability Commissioner Act 1994, and the implementation of the Code of Health and Disability Services Consumers' Rights in 1996.

(a) The Health and Disability Commissioner is an independent statutory watchdog, whose role is to protect and promote the rights of 'health consumers and disability services consumers'. A key function of the role is to receive and resolve complaints about health care providers and disability service providers.[2]

(b) The Code of Health and Disability Services Consumers' Rights 1996 establishes the rights of consumers of health services and the obligations and duties of providers to comply with the Code.

Structural changes

3.7 In 1998, the Health Funding Authority was established to replace the RHAs, and CHEs were reconfigured as Hospital and Health Services.

3.8 On 1 January 2001:

(a) DHBs were established to replace the CHEs; and

[2] Health and Disability Commissioner Act 1994, s 14(da) – (g).

(b) the Health Funding Authority was disesablished and its responsibilities transferred to the Ministry.

3.9 On 1 July 2012 CHFA was disestablished and its property and liabilities were transferred to the Ministry including responsibility for historic abuse claims for events occurring prior to 1993.

3.10 On 3 May 2019, the Ministry provided the Royal Commission with a chronology of the relevant predecessor agencies during the relevant period in response to a request made of the Ministry on 3 April 2019.

Reduction in claims of abuse occurring post-1993

3.11 The structural and philosophical system changes to key New Zealand legislation described above have resulted in a significant decrease in the numbers of patients in state care, and fewer claims of abuse occurring. This reflects:

(a) decreased use of institutional care and increased use of community care;

(b) improvements in mental health treatment and staff training and greater regard to human rights in treatment; and

(c) increased options to identity risk of abuse (such as District Inspectors) and greater independent forums in which to raise concerns about possible abuse (including the Health and Disability Commissioner, the Human Rights Commission, and the Office of the Ombudsman), in addition to avenues for escalation within health services and to authorities such as the Director of Mental Health.

3.12 Any complaints made about events occurring after 1993 are dealt with by individual DHBs (not by the Ministry).

3.13 This provides the context for why the Ministry has subsequently focussed on policies and processes in regards to claims of abuse occurring prior to 1993 (**Historic Claims**). The Historic Claims made have largely arisen out of abuse in psychiatric institutions, however there have also been claims of abuse within general hospitals, although these are rare.

3.14 To the extent that fresh complaints continue to be made about events occurring before 1993 these are now managed systematically by the Ministry in a structured and well-established process, which I will discuss later in this brief.

4 Growing number of claims

Lake Alice Hospital claims

4.1 The Lake Alice Psychiatric Hospital (**Lake Alice**) was situated in Marton. It housed a national high security unit for mentally ill patients. The Child & Adolescent Unit was set up in 1972. It treated children and adolescents with psychiatric and behavioural problems. It ceased operations in 1977.

4.2 Complaints began to emerge in or around 1976/1977 concerning the Child and Adolescent Unit. Former patients of the Child and Adolescent Unit began to

make claims of abuse (including use of unmodified electroconvulsive therapy (ECT) and paraldehyde injections, as well as claims of sexual abuse) while under the care of this hospital.

4.3 In 1977 a Commission of Inquiry investigated the treatment of an adolescent boy who had been a patient at Lake Alice. In the same year, the Chief Ombudsman released a report into practices at Lake Alice.

4.4 During the 1990s, there was increased publicity around former patients of the Child and Adolescent Unit who claimed that they had received ECT, aversion therapy and paraldehyde injections as punishment while at the Child and Adolescent Unit. A number of former patients sought compensation from the New Zealand Government. A joint statement of claim was filed in the High Court in April 1999 on behalf of 88 former patients. They were represented by Grant Cameron & Associates.

4.5 In the early 2000s, the New Zealand Government determined that it would compensate and apologise to former patients of the Child and Adolescent Unit at Lake Alice. Two rounds of settlement followed.

4.6 The Round 1 settlement, which was approved in October 2000, was for the 88 claimants who had filed court proceedings and for another seven former patients (95 former patients in total).

4.7 The settlement was approved up to a maximum amount of $6.5 million. The Crown appointed retired High Court judge Sir Rodney Gallen to determine how the settlement monies should be divided among the claimants.

4.8 Sir Rodney Gallen heard and considered the self-reported experiences of the former patients to determine how the settlement funds might be distributed. He produced a report about his assessment, which provided general comment on the situations and the procedures complained of, and indicated the methodology he had used to allocate settlement monies. The amounts paid out to individuals remained strictly confidential.

4.9 Following the settlement, the then Prime Minister and Minister of Health wrote to each of the complainants and apologised on behalf of the Government for their treatment in the Child and Adolescent Unit.

4.10 The Government decided subsequently to take steps to settle any outstanding or potential claims by former patients in the Child and Adolescent Unit at Lake Alice. This was referred to as the "second round" of Lake Alice settlements. The process for settling these claims was as follows:

(a) A confidential settlement process broadly similar to the settlement of the class action would be used for all second round claimants.

(b) Sir Rodney Gallen would be instructed by the Crown again, acting by and through the Ministry, to determine the quantum of the award to be made to applicants.

(c) There would be Crown funded representation of all claimants or applicants for settlement by Dr David Collins QC.

(d) Sir Rodney Gallen would be instructed to award individual payments to applicants on an equitable basis on broadly similar principles and criteria as in the class action settlement. Sir Rodney was instructed to take into account the absence of substantial legal costs to new applicants.

4.11 In the second round, 90 former Lake Alice patients received compensation. They collectively received $5.7 million, with the average settlement approximately $70,000. Claimants were also sent a personal written apology signed by the Prime Minister and Minister of Health at the time.

4.12 I understand that the Crown decided not to rely on the absolute litigation bar for claims relating to events at Lake Alice prior to 1972 found in the Mental Health Act 1969, or the limitation defences for events after that date, when settling these claims.[3]

4.13 While the formal cut-off date for claims from Lake Alice patients was 1 July 2002, claimants continued to come forward past that date. The Ministry has maintained a separate claims process for any new claims arising out of care provided at Lake Alice. On average, the Ministry continues to receive approximately one new claim a year about the care provided at Lake Alice.

4.14 As a result, the Crown has now paid out a total of $12.6 million, for claims made in respect of abuse occurring before 1993 at Lake Alice, made up of:

(a) $6.5 million to 95 Round 1 claimants;

(b) $5.7 million paid to 90 Round 2 claimants; and

(c) $0.4 million paid out to claimants who presented their claims after Round 2 had closed.

Other claims

4.15 By 2004, it had become apparent that many other former patients of psychiatric hospitals had grievances about their treatment and care while in hospital (not only those who had received treatment at Lake Alice). A number of former patients had commenced litigation against the Crown alleging mistreatment and abuse in psychiatric hospitals throughout New Zealand occurring in the 1960s and 1970s. There were also stories of mistreatment and abuse in psychiatric institutions reported in the media, particularly about practices at Porirua Hospital.

4.16 Between 2004 and 2008, claimants continued to come forward, generally represented by one of two law firms: Johnston Lawrence or Cooper Legal. By 31 December 2007, 181 claims had been filed again CHFA in the High Court in respect of psychiatric institutions, with two key decisions in GRO-B-K *v Crown Health Financing Agency* and *J v Crown Health Financing Agency*.[4]

4.17 While CHFA was a Crown Agency in its own right, the Ministry was its monitoring agency and so had dealings with CHFA in that regard. Those dealings involved

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[3] Cabinet Policy Committee "Grievances of Former Patients of Lake Alice Hospital: Alternative Dispute Resolution Process" (28 September 2000) POL (00) 125. **Crown Bundle - Tab 1**

[4] GRO-B-K *v Crown Health Financing Agency* HC Wellington GRO-B, 16 November 2007; *J v Crown Health Financing Agency* HC Wellington CIV-2000-485-876, 8 February 2008. **Crown Bundle - Tabs 29 and 31**

monitoring CHFA's performance, including its progress on activity relating to historic claims.[5] The Crown Law Office (**CLO**) represented CHFA and also investigated the claims.

4.18 Over this period of four years, between 2004 and 2008, the Crown developed a litigation strategy to respond to these claims. This involved two elements:

(a) If claimants wanted to speak to a non-critical forum and obtain services that promoted wellness and assisted them to move on from historic grievances, they could attend the Confidential Forum or the Confidential Listening and Assistance Services (which I will discuss in more detail later in this brief of evidence).

(b) If claimants wanted a factual inquiry and to seek compensation, they could do so through the Courts.

4.19 Arising out of the Crown strategy came two independent forums:

(a) the Confidential Forum for Former In-Patients of Psychiatric Hospitals (**Confidential Forum**); and

(b) the Confidential Listening and Assistance Service (**CLAS**).

Confidential Forum for Former In-Patients of Psychiatric Hospitals (2005-2007)

4.20 The Confidential Forum was announced by the government in 2004 and established in 2005. The Ministry's involvement in this forum was limited because the process operated autonomously and was funded by Vote Internal Affairs and administered by the Department of Internal Affairs.

4.21 The Māori name for the Confidential Forum is Wānanga (Te Āiotanga) Noho Tapu mō ngā Tūroro i noho ki ngā Hōhipera Mate Hinengaro. Te Āiotanga means tranquillity, calm, peace in English.[6]

4.22 The Confidential Forum had a listening, informing, and reporting mandate and operated between July 2005 and April 2007. It met with former in-patients, family members of former in-patients and former staff members of psychiatric institutions to allow them to describe their experiences of those institutions before November 1992.

4.23 Hearings were held throughout New Zealand. There were 154 days of meetings in 22 different locations between 11 July 2005 and 12 April 2007.[7] By the completion of the hearing process, 493 people had attended a meeting with the Confidential Forum.[8]

4.24 People coming forward to the Confidential Forum were heard by a panel of (usually) three members who had knowledge of the mental health system and

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5 The Ministry's knowledge of the practices at this time also comes from the documents handed over to the Ministry when the CHFA was disestablished in 2012.

6 Confidential Forum for Former In-Patients of Psychiatric Hospitals *Te Āiotanga: Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals* (June 2007) (**Te Āiotanga**), page vi. **Crown Bundle - Tab 24**

7 Te Āiotanga, page 1.

8 Te Āiotanga, page 1.

who were receptive, respectful listeners. The terms of reference noted that the panel would assist the former psychiatric in-patients by providing information and access to relevant services and agencies, including provision for access to counselling.

4.25 Public notices regarding the Confidential Forum were issued throughout New Zealand in national and community newspapers in 2005 and in several ethnic-specific publications in January 2006. Information and flyers in Te Reo Māori and English were sent to a variety of locations, including public libraries, Work and Income offices, Primary Health Organisations, DHBs, community organisations, mental health consumer and provider networks, and general practitioner and nursing networks.[9] Discussion about the Confidential Forum was conducted on a number of iwi radio stations and at several marae.[10]

4.26 The Confidential Forum's processes were designed to be as user-friendly and flexible as possible so as to be able to take into account people's emotional, physical, cultural, spiritual and financial considerations. The letter to participants sent by the Confidential Forum invited participants to advise of any cultural or spiritual protocols or practices they would like observed. It also asked participants to let the Confidential Forum know if they wished to speak to the panel in te reo Māori so that an interpreter could be arranged.[11]

4.27 A trained counsellor would assist the participants in preparing for their meeting. Where participants wished, the meeting commenced with a karakia or a prayer. The participants were encouraged to tell their story in their own words to the panel. The length of meetings would vary, with most lasting around 90 minutes. Nearly half of the participants were accompanied by one or two support people.

4.28 The Confidential Forum was explicitly designed to be non-adversarial and to concentrate on the issues affecting those who attended, rather than to determine the truth of the stories told or to consider compensation. It was designed to accord participants respect and acknowledgement, to assist them to make sense of their experience, and to assist them with access to support and complaint resolution services.

4.29 Participants eligible for counselling could receive up to ten sessions paid for by the Government. These counselling services were arranged for 136 participants.[12]

4.30 The Confidential Forum provided individually tailored information about local and national support services and networks that might be of assistance to participants. A Freephone telephone service allowed participants to contact the Forum in the weeks after their meeting.

4.31 The Confidential Forum also provided linkages and information about other government agencies that could be of assistance, such as the Health and Disability Commissioner, Accident Compensation Corporation, and the New Zealand Police.

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9 Te Āiotanga, page 10.
10 Te Āiotanga, page 10.
11 Te Āiotanga, page 53.
12 Te Āiotanga, page 2.

4.32 Other forms of assistance offered to participants involved information on patient rights and pathways in the medical system. Examples include preparation of Advance Directives concerning future treatment; access to clinical records; and personalised assistance at a very specific level, such as how to obtain a second opinion or information about a treatment that had been undergone. The Confidential Forum also provided information on how to seek legal advice.

4.33 Many participants gave feedback that the Confidential Forum's listening process was useful in their journey of coming to terms with past experiences.

4.34 In June 2007, the Confidential Forum issued its final report, Te Āiotanga: Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals.[13]

4.35 The report sets out the background, purpose, structure and response to the Confidential Forum as well as summarising the general themes emerging from individual experiences recounted during the process. That report is publicly available online through the website of the Department of Internal Affairs (which administered the Confidential Forum).[14]

4.36 The Ministry acknowledges the report as an authoritative portrayal of the accounts of abuse and experiences of the people it heard from.

4.37 The Confidential Forum's final report details the efforts made to ensure Māori were informed of the ability to participate in the Confidential Forum, the variety of locations in which the meetings took place, the flexibility to respond to cultural and spiritual needs in the design of the Confidential Forum processes and the opportunity of participants to tell their story in their own way. It also provided support for individuals to seek legal advice if they wished to pursue a claim through litigation.

4.38 Because of the success of the Confidential Forum, the government of the time decided to extend the listening and assistance service to all forms of residential State care — psychiatric hospitals and wards, health camps, child welfare care and special education homes before 1992. CLAS was established in 2008 to provide that service.[15]

Crown reviews its litigation strategy

4.39 In the wake of the closure of the Confidential Forum, it was apparent that there were a significant number of people who had suffered abuse in State care more generally, over and above those who had been in-patients at psychiatric institutions and other health service providers. The Crown wanted to continue to provide alternative routes for these people to resolve their concerns, rather than turning to the courts.

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13 Confidential Forum for Former In-Patients of Psychiatric Hospitals *Te Āiotanga: Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals* (June 2007). **Crown Bundle - Tab 24**

14 https://www.dia.govt.nz/diawebsite.nsf/Files/CFPages070627/$file/CFPages070627.pdf

15 CLAS was set up to "provide assistance to people ... who allege abuse or neglect or have concerns about their time in state care in health residential facilities (for example: psychiatric hospitals and wards, and health camps, but excluding general hospital admissions), child welfare or residential special education [homes] prior to 1992" (Terms of Reference for CLAS, contained within the CLAS Final Report). **Crown Bundle - Tab 72**

4.40 Following the issue of Te Āiotanga in June 2007, the Crown reviewed its litigation strategy. CLO originally chaired the group which comprised of Chief Legal Advisors from the Ministry (myself) and the Ministries of Social Development and Education as well as a representative from CHFA.

4.41 The Crown agreed that:

(a) The current strategy should be continued, meaning that:

(i) officials would attempt to settle claims where there was a good evidential basis to do so, even if there were legal impediments to a claim being brought (eg, the Limitation Act or the Accident Compensation legislation, which bars many claims for personal injury because of the scheme offering 24-hour, no fault insurance of personal injury that the Government has run since 1974);

(ii) claims would not be settled simply because it was more economic to do so; and

(iii) claims that could not be settled would be defended in Court.

(b) The work done by the Confidential Forum process should be expanded to anybody who had been abused in state care before 1992, rather than limited to specifically psychiatric institutions. This is one of the factors that resulted in the establishment of the Confidential Listening and Assistance Service addressed below.

(This agreement will be referred to as the "Crown Litigation Strategy").

4.42 This group continued to meet usually bi-monthly between 2008 to approximately 2012 to discuss a comprehensive strategy to respond to claims across the health, education, social development sectors, among others. We discussed matters relating to the conduct of historic abuse claims in order to confer about the different practices and processes undertaken by each agency. The group had an overarching goal of supporting consistency between each agency's responses to claims, mainly in terms of conduct of litigation because that was the main method of responding to claims at that time.

Confidential Listening and Assistance Service

4.43 In 2008, CLAS was established by the government as an independent agency to provide assistance for people who had suffered abuse and neglect in State care before 1992. CLAS was originally intended to have a lifespan of five years, however in April 2012 Cabinet approved an extension until 30 June 2015.

4.44 My specific experience with CLAS was from 1 July 2012, when the Ministry took over responsibilities from CHFA and I would receive claim referrals from CLAS on behalf of the Ministry and also queries from CLAS on matters from time to time, primarily through its Executive Director (Gordon McFadyen).

4.45 Throughout the seven years it operated, 1103 people participated in CLAS, including many Māori. 670 people identified as European/Pākehā, 411 identified as Māori, 21 identified as Pacific and one as Asian.[16]

4.46 The Panel included members with considerable experience in Māori culture, including:

(a) Bobby Newson, JP, Tarakeha Te Maunga, Matihetihe Te Marae, Tao Maui Te Hapu, Te Rarawa Te Iwi and Mitimiti Hokianga, with over 40 years of service to the public beginning in Māori Affairs and the Māori Land Court. He has a Bachelor of Māori Studies and has lectured in Māori theology and spirituality, and is a certified translator and interpreter of Te Reo Māori.[17]

(b) Doug Hauraki, Ngati Porou, Ngati Kahungunu and Nga Puhi, with over 40 years of management experience in a variety of public and private sector positions including many years as the Chief Executive of Māori Education Trust, Chief Executive of Aotearoa Traditional Māori Performing Arts Society, Deputy Māori Trust, National Director Māori Development in the Department of Social Welfare and senior roles in Māori Affairs. He is a fluent speaker of Te Reo Māori.[18]

(c) Janice Donaldson, who had held governance roles in Te Ture Manaaki, a Māori legal service and had experience with Māori workforce and provider development initiatives with DHBs and with community providers including Ngai Tahu Development Corporation. Ms Donaldson had also provided strategic advice on community engagement processes with Māori, including the development of Treaty relationships and the development of close working relationships with kaumatua, taua and Māori staff.[19]

4.47 CLAS noted that it had a backlog of claims throughout its operation, however it managed to see approximately 200 people every year.[20] CLAS met with 101 people in 2009; 206 people in 2010; 189 people in 2011; 206 in 2012; 206 in 2013; 186 in 2014; and a further nine in 2015.[21]

4.48 Twenty per cent of those who were heard by CLAS had been in psychiatric care and in health camps. The stories told by these people echoed those heard by the Confidential Forum.[22]

4.49 Participants were given the opportunity to meet with the CLAS Panel, have their story recorded, and identify the assistance that they required. The broad range of assistance offered fell largely into the following categories:

(a) listening;

(b) access to, and talking people through, their personal files;

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16 Chair Judge Carolyn Henwood *Some Memories Never Fade: Final Report of the Confidential Listening and Assistance Service* (June 2015) (**CLAS Final Report**), at 18. **Crown Bundle - Tab 72**

17 CLAS Final Report, at page 42.

18 CLAS Final Report, at page 42.

19 CLAS Final Report, at page 43.

20 CLAS Final Report, at 11.

21 CLAS Final Report, at 18.

22 CLAS Final Report, at 29.

(c) counselling – CLAS funded up to 12 sessions of counselling, to support a participant afterwards; and

(d) referrals to government agencies.

4.50 There was a targeted radio campaign on iwi radio. [23] The CLAS Chair offered participants an opportunity for karakia or other relevant protocol.[24]

4.51 "Health" was one of the areas which received a number of referrals from CLAS. Referrals were made in some form in 69 per cent of cases. CLAS made 87 referrals to CHFA/the Ministry.[25] In its final report, CLAS noted that the Ministry responded to and settled referrals quickly, often within weeks.[26]

Disestablishment of CHFA

4.52 In August 2011, a decision was made by Cabinet to disestablish CHFA and transfer its functions, as part of a process of reducing the number of state agencies. That agency had been the main recipient and defendant of Historic Claims (including the claims about Lake Alice).

4.53 In early 2012, prior to its disestablishment on 1 July 2012, CHFA, in conjunction with Crown Law and the Ministry, undertook a process approved by the Minister of Health and the Attorney General, seeking to settle claims that had been filed with the Courts against CHFA relating to treatment of patients at psychiatric facilities operated by former Area Health Boards. In the lead up to the disestablishment of CHFA, $5 million was available for the settlement of these claims and it was decided that these funds would be used by CHFA to achieve settlement of existing claims.

4.54 As of December 2011, approximately 300 claimants had filed proceedings against CHFA in relation to Historic Claims.

4.55 The claims process had been set up because it had become apparent that litigation was an unsuccessful and inappropriate avenue for redress of Historic Claims. This was because:

(a) as previously explained in this brief, the Mental Health Act 1911 and its successor, the Mental Health Act 1969, contained very restrictive provisions in respect of claims up until the enactment of the 1992 Mental Health Act (as confirmed by the Supreme Court decision in *B and ors v CHFA* [2009] NZSC 97);

(b) even if plaintiffs were not caught by these statutory restrictions, they faced significant difficulties proving their claims to the standard of proof required due to the passage of time since the alleged abuse had occurred; and

(c) the delays of going through the justice system resulted in plaintiffs incurring substantial Legal Aid liabilities.

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23 CLAS Final Report, at page 17.
24 CLAS Final Report, at page 58.
25 CLAS Final Report, at 18.
26 CLAS Final Report, at 21 and 73.

4.56 The Ministry CHFA considered that a global settlement of claims outside of court was the best approach to resolve these filed claims and any claims received up until because:

(a) they represented a finite pool of old claims about events largely in the 1960s and 1970s;

(b) in 1992 the law relating to the treatment and care of mental health patients changed considerably – therefore there are now options for resolution of disputes within the new legislative framework;

(c) it enabled CHFA to efficiently settle a large number of claims; and

(d) it provided claimants with a means to exit litigation with dignity, and without a debt, and to move forward in their lives by providing some assistance for meeting their wellness related costs.

4.57 The settlement was negotiated between CLO and Cooper Legal (who by that time had assumed responsibility for the claimants previously represented by Johnston Lawrence).

4.58 The settlement offer to claimants included:

(a) a letter of apology from CHFA;

(b) payment of a settlement sum ranging from $4,000 to $18,000 (depending on the level of abuse and the quality of supporting evidence) in acknowledgement of a claimant's experiences in psychiatric hospital care and of the costs the claimant had incurred in seeking wellness in the period since the claimant's treatment;

(c) settlement of outstanding legal aid liabilities, with CHFA paying half the outstanding amount and the Legal Services Agency (now part of the Ministry of Justice), writing off the remaining amount; and

(d) payment of legal costs associated with the settlement.

4.59 To the best of my understanding, it was agreed with CHFA that Cooper Legal (on behalf of the claimants they represented) would assess the claims on the basis of seriousness, the nature of the abuse that took place, how they compared against each other and the funding available (including to settle legal aid liabilities) and categorise them as follows:

Category	Criteria	Amount paid (with apology)
1	"Worst" abuse – typically involves allegations of repeated serious sexual abuse and physical abuse or where plaintiffs were young and therefore regarded as being more vulnerable.	$18,000
2A	Typically claims that allege physical abuse and/or some sexual abuse of a less serious nature than Group 1. It may also include allegations of	$12,000

	seclusion, ECT as punishment.	
2B	Typically claims that allege physical abuse and/or some sexual abuse of a less serious nature than Group 1. It may also include allegations of seclusion, ECT as punishment.	$8,000
3	Less serious claims that allege fewer physical assaults, relatively short admissions and typically no sexual abuse.	$4,000
4	No corroborating information supporting claims of abuse (only the claimant's account of events).	Apology only

4.60 There was a small group of claimants who had previously discontinued Court proceedings. CHFA adopted the same form of settlement process for them, but the payments were reduced since the claims were discontinued.

4.61 By 30 June 2012, 330 of the 336 claims[27] included in the CFHA settlement process had been resolved. Of the remaining six claims, three offers were declined by the claimant and a further three claimants could not be located.

4.62 These 330 claimants were paid a total of $4.96 million by CHFA, including payments to Legal Aid in settlement of legal aid liabilities of claimants.

2012 – Present day: The Ministry's dedicated Historic Abuse Resolution Service

4.63 On 1 July 2012, CHFA was officially disestablished and all liabilities for Historic Claims were assumed by the Ministry from that date (including responsibility for dealing with all remaining and new Historic Claims, as well as the administration associated with settling the existing claims).

4.64 Following that, the Ministry's Historic Abuse Resolution Service (**HARS**) has dealt with claims of abuse or neglect by persons who were receiving care in a state psychiatric hospital before 1993. The service was approved by the Minister of Health in 2012.

4.65 The Ministry has adopted this process as a way of resolving historic claims in a timely and accessible manner, and it was established in line with the Crown Litigation Strategy.

4.66 The process deals with historic claims, which are those dating from before 1993. The reason for that cut-off date is that from 1993 onwards, legislation (in the form of the Mental Health (Compulsory Assessment and Treatment) Act 1992) and an independent statutory commissioner (the Health and Disability Commissioner, established in 1996) provided for the upholding of rights of those who are in psychiatric care and avenues for people to make complaints about contemporary care.

[27] The 336 claims included as part of the CHFA settlement process was made up of 242 active claims and 94 discontinued claims.

4.67 The Ministry also maintains a separate claims process for claims relating to events at the Child and Adolescent Unit at Lake Alice occurring between 1972 and 1977. That process is managed under a separate Cabinet authority.

4.68 Details of the HARS are discussed below.

5 Proposal to the Minister to establish a Historic Claims process

5.1 After 1 July 2012, the Ministry continued to receive new Historic Claims relating to events prior to 1993 after the CHFA settlement (these were in addition to the 336 claims that had been settled).

5.2 These further claims concerned complaints of sexual and physical mistreatment occurring whilst in the care of publicly funded health institutions, primarily in connection with psychiatric hospitals. In addition, there were also complaints relating to treatment as punishment (including arising from use of medication, isolation and electro-convulsive treatment).

5.3 By 16 October 2012:

(a) 22 new claimants had come forward seeking an apology and compensation from the Crown in light of publicity associated with the CFHA settlement process;

(b) 18 new claimants were referred by CLAS for consideration; and

(c) six new claims were advanced by Cooper Legal.

5.4 The Ministry assessed that this trend of further claims was likely to continue, identifying that more referrals were likely to be made through CLAS (because this forum continued to hear from new individuals until 2015).

5.5 The Ministry considered that, although there was a low risk of legal liability in relation to the claims, the Crown had a moral obligation to acknowledge the claimants' experiences through a settlement process.

5.6 On 25 October 2012, in my role as Chief Legal advisor, myself and another solicitor in the Ministry's Health Legal team submitted a proposal to the Minister of Health to establish a dedicated process for dealing with Historic Claims (ie claims relating to events occurring before 1993) which was to be modelled on the CHFA settlement process.[28]

5.7 We proposed setting up a HARS which was based on the settlement process undertaken by CHFA/Cooper Legal, but with the assessment of claims to be conducted by the Ministry rather than by an external law firm.

5.8 The proposal was as follows:

(a) A claimant writes to the Ministry, providing supporting information (eg medical records, dates, hospitals, staff names, allegations of wrong doing).

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[28] Report from the Ministry to the Minister of Health *Dealing with claims patients with historic abuse claims relating to treatment in psychiatric facilities prior to 1993* (25 October 2012).

Crown Bundle - Tab 61

(b) The Ministry assesses the credibility of allegations based on the evidence available and categorises the claim as follows:

Category	Evidence required	Apology and Wellness payment
1	Reasonable evidence of severe sexual and/or physical assaults, and/or significant period of solitary confinement and/or not authorised by mental health legislation of the time.	Apology and $9,000.
2	Reasonable evidence of low level sexual assault.	Apology and $6,000.
3	Reasonable evidence of low level physical assault and/or less credible claim.	Apology and $4,000.
4	Weak evidence of abuse or improper treatment.	Apology and $2,000.
5	No reasonable evidence of abuse or improper treatment.	No apology or wellness payment. Letter acknowledging the claimant's concerns and the changes that have been made to the mental health system.

(c) The assessment process would be managed from the Health Legal team, drawing upon advice from the Office of the Director of Mental Health as appropriate.

(d) The Ministry makes an offer of a letter of apology and/or a wellness payment, based on the category of the claim. The wellness payment offer was to be on similar terms as the CHFA settlement offer in that:

(i) the Crown would not make any admission of legal liability; and

(ii) the claimant must undertake that, upon receipt of the wellness payment and letter of apology, they will not bring any future proceeding in any court against the Crown relating to any act or omission that occurred prior to 1993.

(e) If a claimant accepts the wellness payment offer, the Ministry issues the letter of apology and processes the payment on receipt of the claimant's undertaking.

(f) If a claimant challenges the wellness payment offer, then the Ministry considers the submissions from the claimant (which may include additional information that they wish the Ministry to consider or where the claimant has concerns that the Ministry may not have given sufficient weight to the concerns raised or is inconsistent with other offers made).

5.9 The wellness payment figures in the table were based on previous offers made by CHFA for similar unfiled claims in recognition of experiences and contribution towards rehabilitation, but discounted to reflect the fact that no legal proceedings or costs had been incurred by the claimant. The wellness payment is intended be in full and final settlement of any claim.

5.10 In the absence of additional funding being appropriated, we proposed that the funding be sourced from the Ministry's Non-Departmental Other Expenses Legal Services budget. This is the budget from which other historic claims settlements (such as Lake Alice and Hepatitis C) are met and from which the legal costs of such claims would have been met in the event Court proceedings were filed.

5.11 The Ministry intended the process to be as efficient as possible, so as to avoid re-traumatising survivors of abuse and to enable claimants to have prompt resolution of their claims.

5.12 On 25 October 2012, the Minister of Health approved our proposal.

6 Historic Abuse Resolution Service in practice

6.1 It was late 2012 when the first claims were processed by the Ministry using the HARS. By that time there was a backlog of claims (approximately 30) that had been made in the interim between the CHFA settlement and establishing the HARS process.

6.2 The Ministry was primarily reliant on CLAS referring survivors to the Ministry (up until CLAS was disestablished in 2015). We also relied on referrals from other agencies, such as the Ministry of Justice or the Ministry of Social Development. Some claims were made directly to the Ministry:

(a) as a result of information received through word of mouth or through media coverage; and

(b) through law firms (primarily, Cooper Legal).

6.3 When individuals contacted the Ministry, we advised potential claimants that they could make a claim for abuse in psychiatric care prior to 1993 and informed them that they would need to provide information about the abuse suffered and a consent form so that the Ministry could access their information from the relevant DHB (as DHBs continue to hold historical hospital records).

6.4 To my knowledge, where records are still held by DHBs and able to be accessed, there have not been any significant issues with claimants being unable to access their personal information/hospital records. That is because, copies of patients' health records are made available in full, without redactions, unless those records cannot be accessed (such as for health and safety reasons, in the case of Cherry Farm records). This reflects that these are usually the medical records for the individual and to extent those notes may contain reference to other individuals, disclosure is not considered to be an unwarranted interference with the privacy of those individuals.

6.5 The Ministry considers the claim on the basis of the information available. Where records do not exist, or are unable to be accessed (ie Cherry Farm patient records are unable to be accessed for health and safety reasons), then the

Ministry will consider the claim on the basis of the information provided by the claimant, as long as confirmation is available that the person was held in care.

6.6 The Ministry considers that the HARS process has been administratively efficient. We aim to issue claimants with a decision on their claim within four to six weeks from receipt of their personal information from the relevant DHB, and have generally achieved that turnaround period. As at 30 November 2019, we identified that 60 per cent of claims were settled within three months of the Ministry receiving the claim, and 86 per cent of claims were settled within six months.

6.7 Another issue in practice is that notwithstanding that the offers are made on the basis of being a full and final settlement, the Ministry has been prepared to consider subsequent requests to reconsider the settlement amount (after payment) in situations where individuals can provide new information for the Ministry to consider and explain why it was not previously provided.

6.8 Offers to resolve any claim are made notwithstanding any legislative restrictions, such as the Mental Health (Compulsory Assessment and Treatment) Act 1992, Limitation Act 1950 or the Accident Compensation Act 1972, which might otherwise restrict a claim if it was made to the Courts. On occasions where individuals request copies of records provided to the Ministry by the DHB, as noted above these are provided in accordance with the Privacy Act 1993 without redactions (unless there is concern about health or safety).

7 The Ministry's current day practice

7.1 Since establishing the HARS in late 2012 the Ministry has continued with the same practice for receiving and processing Historic Claims. As the Ministry's Chief Legal Advisor, I have overseen the process since its inception.

7.2 The process for managing these claims today is straightforward. The process ran largely in terms of its original proposal as outlined above. It can be summarised as follows.

Entry into the Ministry process

(a) A person or their representative (it does not have to be a lawyer) must notify the Ministry that they wish to make a claim. Notification can be by letter, telephone or email.

(b) There are a number of avenues through which the HARS can be accessed. Initially, the majority of the referrals were through the CLAS. Referral details are available through the still-functioning website of the disestablished CLAS service. In addition, contact with the HARS can be made directly to the Ministry through its call centre or by correspondence. Contact is also sometimes made by referral from Ministers or Members of Parliament on behalf of their constituents, or on referral from other agencies.

Information gathering

(c) On receipt of the claim, the Ministry will send a letter to the claimant explaining the process and requesting the claimant's written

authorisation allowing the Ministry to access their medical records from the psychiatric hospital where they allege abuse took place.[29] The Ministry does not request specific demographic data (such as age, gender, ethnicity, disability) as part of the process or design its process based on such demographics.

(d) The letter also asks the claimant to record their recollection of the details of the alleged abuse suffered and send that to the Ministry. The record can be by letter or email. Where information cannot be provided in writing, this is usually managed through information being provided by phone or by the person's representative. There is no face to face interview. This allows claims to be processed as efficiently as possible, assists the Ministry to process claims within the limited resources it has available to operate the HARS, and takes into account health and safety considerations.

(e) Once the Ministry has received the claimant's written authority to access relevant medical records, that information is requested from the appropriate DHB.[30]

Assessment

(f) A senior investigator at the Ministry then reviews the written record and the relevant medical records, after which I, as Chief Legal Advisor of the Ministry, assess the claim.

(g) I then hold a meeting with the senior investigator to consider the claim. The investigator will give an oral summary of the claim, we discuss documentation setting out the basis of the claim (in whatever form provided, whether written or notes taken from oral discussion with the claimant) and we assess the available records for any information which supports the claim.

(h) I then assess whether the claim is sufficiently made out and which of the five categories it falls into (as noted above the categories range in seriousness depending on the level of abuse alleged). I base my assessment on the circumstances as a whole, the gravity of the alleged abuse, and the supporting evidence available. There is no hard and fast yardstick against which claims are assessed – in practice I would describe it as whether it is reasonable to believe that the abuse may have taken place, for the purpose of making a settlement offer.

(i) The assessment is made on the best information available but does not involve a verbal interview (unlike CLAS process which did involve a verbal hearing).

Findings and offers

(j) The Ministry's response to the claim is typically given to the claimant within four to six weeks after relevant medical records are received. If the claim is made out, the response will involve an offer of an apology

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29 Ministry's template letter – Explanation of Claim Process. **Crown Bundle - Tab 97**

30 Ministry's template letter – Request for Medical Records. **Crown Bundle - Tab 98**

and usually a wellness payment (up to $9,000) that can be used for any purpose.[31]

(k) To accept the offer the claimant needs to respond in writing accepting the offer and advising of their bank account number.

(l) If the claimant rejects the Ministry's offer, a review of the Ministry's decision can be undertaken if further relevant information is provided.

(m) The Ministry does not make any admission of legal liability. The claimant must undertake that, upon receipt of the wellness payment and letter of apology, they will not bring any future proceeding in any court against the Crown relating to the same claim of abuse for which they have received a payment from the Ministry.

(n) Once accepted, the Ministry will send a letter of apology and make the wellness payment into the designated bank account within five days of receiving the claimant's acceptance of the Ministry's offer.[32]

(o) The file is then closed and the Ministry will not consider any further complaint or claim for the same matter, unless further new relevant information is presented. A settlement letter is issued noting that the apology and payment (if made) is made in full and final resolution of the claim.

(p) The Ministry offers to pay a claimant's legal costs of up to $2,000, or in the case of Cooper Legal, the claimants are legally aided and the Ministry meets 50 per cent of the legal aid costs (the Ministry's share is usually between $1,000 and $2,000, and the remainder is written off by the Ministry of Justice).

7.3 The levels of compensation offered under HARS are broadly consistent with the settlement amounts that were offered by CHFA prior to its disestablishment in 2012 to persons who had not filed claims with the Courts. Current compensation levels maintain overall consistency with claimants who settled under previous resolution schemes.

7.4 Although there is no publicly available statement on the Ministry's website explaining this process, the Ministry is confident that potential claimants have sufficient information to make a claim because there have been official and well-publicised channels for making complaints since at least 2003, when the first claims for redress were filed in the courts, and up until CLAS was disestablished in 2015.

7.5 The Ministry considers that the HARS accommodates tikanga Māori to a certain extent, by way of its ability to respond flexibly to specific cultural or tikanga-based requests when they are raised by a claimant.

7.6 The Ministry does not keep records of how many Māori individuals have used the Historic Abuse Resolution Service. However, issues of cultural

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31 Ministry's template letters – Offer of Settlement (Cooper Legal and non-Cooper Legal versions). **Crown Bundle - Tab 99**

32 Ministry's template letters – Apology (Cooper Legal and non-Cooper Legal versions). **Crown Bundle - Tab 100**

appropriateness and tikanga have not been raised with the Ministry in relation to that service.

7.7 The Ministry recognises that the HARS does not explicitly incorporate tikanga into its design. The Ministry acknowledges this is a shortcoming, though it has not been raised in the administration of claims to date. The Ministry is prepared to consider how tikanga could be recognised and implemented more explicitly and proactively within the process going forward.

Limitation issues

7.8 Offers to resolve any claim are made notwithstanding any legislative restrictions, such as the Mental Health (Compulsory Assessment and Treatment) Act 1992, Limitation Act 1950 (and 2010) or the Accident Compensation Act 1972, which might otherwise restrict a claim if it was made to the Courts.

Litigation costings

7.9 The Ministry of Health has paid out a total of **$12.6 million**, for claims made in respect of abuse occurring before 1993 at Lake Alice, made up of:

(a) $6.5 million to 95 Round 1 claimants;

(b) $5.7 million paid to 90 Round 2 claimants;

(c) $0.4 million paid out to claimants who presented their claims after Round 2 had closed.

7.10 Between 1 July 2012 and 30 November 2019, 223 claims have been settled by the Ministry through the HARS process (without court proceedings). **As at 30 November 2019, the Ministry has paid out a total of $1,338,000 to claimants**.[33] That amounts to an average payment of $6,000 per claim.

7.11 I note that there have been no court proceedings filed against the Ministry to my knowledge and therefore there are no litigation costs that I am aware of, excluding litigation costs that will have been incurred by CHFA prior to 1 July 2012.

8 Concluding remarks

8.1 By way of concluding comments, I wish to highlight some of the key features arising from the history addressing claims of abuse arising in the context of public healthcare, particularly since the early 1990s.

8.2 Since 1993, there has substantial change in mental health and psychopaedic care which means current public healthcare systems have substantially improved.

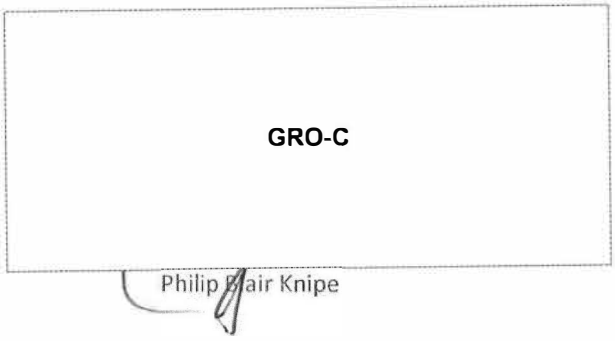
8.3 The government's acknowledgment of concerns with the care provided by Lake Alice Child and Adolescent Unit, together with the apologies and settlements made, were the start of a formalised approach of redress for abuse in public health care.

[33] This excludes the funds paid to Legal Aid by the Ministry for claimant's Legal Aid costs.

8.4 Following settlement of the Lake Alice claims, government funded listening processes were put in place and these provided a forum for people to be heard, to tell their story and for learnings to be taken on board to further reduce risk of similar abuse occurring in future.

8.5 The settlements achieved by CHFA in 2012 and the subsequent HARS process adopted by the Ministry since then had pragmatic origins designed to address claims of abuse in public healthcare in a fair and respectful manner. While the processes may not be as tailored to individual needs in comparison to other redress processes, in practice the design of the processes has had significant benefits. They have been efficient and accessible for claimants and minimised the evidential burden on claimants. Importantly, they have taken into account the need to minimise the risk of re-traumatising claimants.

8.6 I am available to answer any further questions that might assist the Royal Commission.



Philip Blair Knipe