STATEMENT OF JUDGE CAROLYN HENWOOD

DATED: 28 October 2019

Introduction

[1] My name is Carolyn HENWOOD. I am a retired District Court Judge. I chaired the Confidential Listening and Assistance Service (the Service), which was established in 2008 as an independent agency to provide assistance for people who had suffered abuse and neglect in State care before 1992.

[2] Tabled to this evidence is the 2015 report of the Confidential Listening and Assistance Service "Some Memories Never Fade". It contains content of the comprehensive work done by the Service, the staff and panel members.

[3] I am participating in the Royal Commission's work by giving evidence to ensure, as far as possible, that the voices of the 1,103 individual New Zealanders who came forward to the panel, are included in the process of this important Royal Commission. In this way those who cannot or do not wish to come forward again, will know that their views as far legally possible are being heard at this important Commission.

Who were they?

[4] There were 1,103 New Zealanders, 552 women, 551 men and they attended hearings in 23 different locations throughout the North and South Islands of New Zealand, with one meeting in Australia. 670 of those persons identified as Pakeha, 411 persons identified as Maori, 21 identified as Pacific, 1 as Asian.

What did they have to say?

[5] It is important to me to say at the outset, that almost every individual person that came before the Service expressed, as their reason for doing so, not only to tell their own story but

to hope that there would be a better care system for the young people of New Zealand in the future.

[6] I would also like to make it clear, that at the panel hearings, most individuals came forward to speak about their life experience. In so doing, did not immediately accuse the Government of wrongdoing or criticise staff or social workers. Many of them did not even know they had a social worker.

[7] Our panel formed the view, after listening to the stories of those people, that their main concerns, as children, were that they felt abandoned; that they had lost their identity and that they were not safe. When bad things happened to them, they did not feel heard and they had no one to turn to for support. Many reported significant physical and sexual abuse; a punitive culture of care; stigma and a very unsettled and unstable lifetime. They told us that there was no continuity of care and they were moved constantly.

[8] Many were angry and disappointed at their life outcome. They wanted to see their files which were held by the Ministry of Social Development to know whether they were entitled to an apology. Some wanted to know whether they were entitled to more than an apology and they wanted us to help facilitate communication with the Department so they could get a deeper understanding about what had happened to them as children.

[9] One of the significant problems that we faced, was receiving files for the participants with large pages of redacted, blacked out material.

[10] I would like to read a personal tribute that I made at the beginning of the report in June 2015, because it encapsulates the way our panel and our Service felt.

[11] A PERSONAL TRIBUTE:

> At the close of the Confidential Listening and Assistance Service (the Service), I must pay tribute to all those New Zealanders who came forward at the request of the Government, to report their concerns for abuse and neglect in State care. Our panel members were profoundly affected by what each person had to say. As the numbers grew and more voices were heard, a picture was painted for us of a careless, neglectful system, which allowed cruelty, sexual abuse,

> bullying and violence to start and continue. Through their words and tears, we could see the invisible welts and bruises, as well as the deeper hurt and emotional damage. They told us they were not watched over, nor protected. They were not valued, not heard, not believed and not safe. All the people who came forward to speak to us had struggled to make sense of their lives; all wanted to make a better outcome for the children of the future. We made a commitment to listen to them and to pursue a safer and more professional care service with a genuine framework of accountability for the future.

[12] We were honoured by the dignified way the participants conducted themselves throughout those years. They attended in person and with family or whanau. No lawyers were present, but occasionally a counsellor attended. It was better when there were not professionals present, because it allowed the voice of the participant to be heard, which was our goal.

[13] I cannot tell the Royal Commission individual stories, but I can draw attention to the common themes and the participants' views of systemic failures.

The Service Background

[14] There is some background to the establishment of the Service which I came to understand once I was involved.

[15] I understood that in the early 2000s, there was an increasing number of allegations from people who had concerns about the care they received when placed into a residence, family home, special school, or foster care, as well as psychiatric care. While I was not present for these discussions, in 2007 a package of measures was agreed between social and justice sector agencies relating to this issue; the creation of the Service, to be independent and chaired by a Judge, was one of those measures.

[16] The Service was to be funded by participating agencies but administered by the Department of Internal Affairs. It was estimated to have a lifespan of five years, however extension until June 2015 was approved by Cabinet in April 2012.

[17] I accepted my appointment to the Service on my understanding that it would be an innovative response, similar to South Africa's Truth and Reconciliation Commission, to this issue.

[18] The process used by the Service, including how the Service engaged with the participants in different settings including the prisons, is outlined at Part 2 of the Report.

Terms of Reference

[19] The Terms of Reference are outlined at Appendix 2.

[20] In the beginning, the Terms were very limited, Amongst other things, the Service was not to determine liability, or the truth of the participant's experiences or stories, pay or recommend the payment of compensation, judge participants or anyone mentioned by a participant, or reach a conclusion about what or might not have happened, including recommending a particular course of action to address issues raised, in anyway attempt to resolve differences, acknowledge liability or make an apology for any past actions of any official, report to Ministers to share or make public any information relating to specific participant's stories it hears or make any public comment about those stories, or allow participants to have legal representation at the meetings.

[21] Later, because of the restrictive nature of the Terms, an application was made to Cabinet to amend them to include the Service being able to report to Ministers on consistent themes and legacies of effect.

[22] Our Service felt it was a squander and a waste not to get accumulated knowledge from all the people who had come forward to tell us things with the expectation that something would be done with that knowledge to make life better for the young people in care in the future.

[23] Cabinet agreed to that and the Report which has been tabled has those common themes and legacies of effect.

[24] The final Terms provided both positive elements as well as challenges due to the limitations of the Service.

[25] Even though the Terms of Reference was restricted, we used our best endeavours to engage with the participants and to provide as much time to them as we could. In other words, we had no money or funding or compensation that could be paid, but we tried to provide time through phone calls, letters, panel hearings and follow-up, to make and engagement with the Service as positive as it could be under the circumstances.

[26] We did not embark on an exercise to assist participants to come to terms with their experience and to achieve closure. We offered as much help as we could without speaking of closure.

[27] We noted at that time, it was common for survivors or participants to be told that what had happened to them was "*the social work practice of the day*". This was not, in my view, a useful statement to be said to those who had concerns about their time in State care. We, as a Service, did not support the use of words or phrases in an attempt to explain away what might have happened to them, or to talk about closure.

[28] Overall, it was our view that the Service was able to achieve some positive outcomes for participants. I will outline below the successful features of the Service and the most important aspects of our work. This is followed by the challenges which I outline to demonstrate to this Royal Commission some learnings which may be of value.

[29] Our main purpose was to provide advice and assistance to participants who alleged abuse or neglect or had concerns about their time in State care.

Assistance[1]

Listening:

[30] The value of being heard; of having someone listen, in a non-judgmental and constructive way, cannot be underestimated.

[1] Appendix 5, page 54 of the Report, records a table of the support provided.

[31] Participants reported that they felt respected in the panel meeting environment. Most had never spoken their entire story at one sitting. After a panel meeting many were surprised that they had spoken for nearly two hours and that the time had gone so quickly.

[32] Forty-four people disclosed their sexual abuse for the very first time.

[33] The participants, when they attended, brought family with them, although they were not to be accompanied by lawyers. As we were not in a position of making findings of fact or being able to offer compensation, this enabled a free atmosphere, where the participants could speak to us openly and they did so.

Continuity of contact:

[34] Following registration, the participant had one single Facilitator to manage their engagement. Facilitators ensured the Participants were fully briefed before they came to give evidence. Facilitators had experience in health and psychology as well as education.

[35] A direct follow-up between the Participant and the meeting Facilitator occurred the day after their meeting

[36] Within 48 hours a letter was written to thank the Participant. I vetted and signed every letter. Participants were free to call us whenever they liked and we received a great many calls.

CD Recording of Panel Hearing

[37] 970 participants requested the CD recording of their panel which was sent to them within a day or two of the hearing being held.

[38] We did not retain the CDs long-term, as we were instructed by the Department of Internal Affairs not to do so. These were private recordings of private hearings and were not to be published.

[39] I would expect the Royal Commission to be willing to accept these CDs from any participant who wishes to provide theirs as evidence.

Requests for Files

[40] It was a surprise to many that they could apply to receive a copy of their Social Welfare files or hospital records. 86% of those who attended a panel meeting requested their files, which came to the Service at first to ensure a level of support was available to the participants reading the files, before being couriered on to the participant.

[41] The support in reading the file was very important, as participants would likely find very confronting information, such as their parents still being alive.

[42] Initially there was a very long delay between the request and the files being received, sometimes two years later. This began to reduce over time.

[43] There were heavy redactions which were confronting for both participants and the staff of the Service. One of the purposes of the Service was to assist with making corrections on available information held about them by the State, but this was unfeasible. Files would arrive filled with so many redactions that it was not possible to begin to correct the errors.

Referrals to Services, Agencies or Institutions

[44] The Service could fund up to 12 sessions of counselling to support a participant afterwards, about 62% of participants were offered counselling. Private and relationship counselling were available.

[45] Where possible we engaged ACC-registered counsellors so that ACC-funded counselling could follow on seamlessly when the sessions funded by the Service concluded.

[46] The Service also made referrals to assist with an investigation into the participant's case with the responsible agency, and referrals were made in 69% To claims or legal teams within government agencies, the Police, Māori providers, the CEO of Children's Health Camps, the Ombudsman/Privacy Commissioner.

Advocacy and Pastoral Care:

[47] The Facilitator would also offer advocacy to help the participants in their lives now, get their power put on, provide and help get new housing, jobs and many other strands of assistance.

[48] While not planned for at the outset, after a period the CDs were given by the Service directly to relevant agencies to assist where a Participant was making a claim. As the Panel convened to listen, not determine, and involved no representative of the relevant State agency, the facilitation of Participant consent to the release of the CD allowed for Participants making a claim to avoid both the retelling of their story and a more adversarial experience.

[49] We negotiated with ACC to get long-term counselling for sexual abuse.

[50] There was a huge amount of work done by our facilitators, including referrals and advocacy and many creative outcomes. The pastoral care was a very strong arm of the assistance that was provided by our staff and the work done was innovative and wide-ranging. I was very proud of the work done by our facilitators, who engaged with different persons, sometimes for months or years on end.

Faith-Based Institutions

[51] In line with our Terms of Reference, the Service could only accept a referral from participants who were looking to speak about their experience in faith-based care if they had been placed in the care of such an institution by a Department of Social Welfare social worker or the Courts.

[52] In the process of establishing the Service we had identified points of contact in the various faith-based institutions that provided care. We kept these institutions fully informed of our work and established referral protocols with them.

[53] If potential participants contacted us and were unsure of how they had been placed with one institution, we were able to refer them directly to the name of someone from that institution. We also offered them the option of the Service contacting the Ministry's Historic

Claims Unit on their behalf, with their appropriate consent obtained in writing, to determine if they had been in State care before they were placed in into faith-based care.

[54] If we were confident the State had had a role in the placement of a participant in a church organisation, we accepted the referral. The participant was then treated like all of our participants and depending on the recommendations of the Panel, a referral would be made to Historic Claims and the relevant church for files, investigation and possible settlements.

[55] While I do not have access to the number of people who contacted us who had concerns about their time in the care of a faith-based organisation, it was a significant number. Some of the churches included The Salvation Army, the Catholic Church, the Methodist Church, the Anglican Church. We do know that the Salvation Army, the Catholic Church and the Methodists did provide files and did provide apologies and compensation directly to our participants.

[56] Many of our older participants were not able to find records of their time in care which was distressing for them. Their stories were harrowing, and their experiences had severely impacted their lives.

Challenges

Terms of Reference Limitations

[57] The Service had no powers to require or compel evidence in order to determine liability or truth. While a constraint, this allowed participants to freely give the depth of their story in a non-adversarial setting.

[58] We were not set up to offer apologies or compensation which meant people had to been seen separately. The process of settlement was not transparent even to parties. We were only able to offer our time to listen to the participant's story.

[59] The Service was also limited in terms of timeframe, pre-1992 being selected due to a perception that the systems in the relevant social and justice agencies had sufficiently changed following that time.

Capacity and Closure of the Service

[60] The Service was limited in terms of infrastructure, with only five highly dedicated staff members who did this work for the seven years, aside from myself and the Panel members. With this limitation the Service had to be nimble and creative with our innovations. As a result of the lack of budget and staff support, we could not advertise widely, and likely people were unable to access or unaware of the Service as a result.

[61] With the requirement to close off registrations in 2013, more than 150 people contacted the Service and had to be referred on to their relevant government agency with no further assistance. The disappointment in knowing that some people would be left "up in the air" was significant. With the issue of the lengthy delay in receiving files from State agencies, there were a lot of participants left feeling as if they did not know what was happening to their case.

Engagement in the Prisons

[62] Despite, from the outset, having a Memorandum of Understanding with the CEO of the Department of Corrections, arranging meetings with participants in the prisons was complex, and at times felt impenetrable.

[63] There were issues of security and communication with prisoners, and issues with security and staff remaining present and listening when a meeting was arranged.

[64] From a practical standpoint, as wanted to provide the same service that we did for those in the community, like food and particular furnishings, and therapeutic engagement, which often required providing a support person for the prisoner following the meeting to ensure that the prisoner was not returning to an untherapeutic situation afterwards, particularly with regard to those in solitary confinement.

[65] Advertising through the prison was difficult and the reality of the Service was that registration needed to occur well in advance to allow for a panel to take place. Many prisoners who had registered had left prison before we were able to meet with them and we lost contact, and many inmates who remained in prison did not have the opportunity of meeting

the Service. Our existence had only begun to spread amongst the prisoners despite extensive engagement with prison staff over the years.

[66] While the Service visited 18 prisons and saw 131 prisoners over 67 dates and had the benefit of being able to refer participants on a counsellor within the prisons, my view was that there were many hundreds if not thousands of people who had not been reached.

[67] In many instances, prisoners reported that the first time they had the courage to speak about their difficult childhoods and that the opportunity to talk about their experiences in State care brought about significant changes in their lives.

[68] While I could not sit on the prison Panel interviews due to my conflict as a member of the Parole Board, I am aware of at least one example where a man later appearing for a parole hearing was described as “unrecognisable” by his wife following his engagement with a panel hearing. For many prisoners who have come through care, behind their criminal offending is hurt that has never been spoken about.

[69] Dr Barbara Disley kindly took on the role of Chair for the panel hearings in the Prisons, and she has said "after the mental health inquiry I was left with the view that if there was one thing we could do as a nation it would be to do whatever possible to remove abuse, trauma and violence from every child’s life”. She knows that the people currently incarcerated will be foremost in my thoughts as I talk to the Royal Commission on behalf of those who spoke to the service.

[70] I am convinced that this work contributed to the lowering of inmates’ risk of re-offending as the process of being able to therapeutically address childhood trauma for some inmates began with the Service by listening to their story, and assisting with quality pastoral care and counselling for prisoners.

Common Themes

[71] The common concerns for participants were regarding placements, institutional practices and punishments, monitoring and support, physical, emotional and sexual abuse, psychiatric treatments, health camps and social work practice failure.[2]

Placements

[72] There was extensive concern around placements. I would like to highlight that today, because the same issue confronts Oranga Tamariki. That list covers everything from the children being removed from the home and not told why; placed in mismatched, inappropriate and poor foster home placements; not enough effort being made to find family members to care for the children; being placed with offenders and many other criticisms, including widespread alcohol abuse, not only in the families of origin, but in foster families leading to child neglect, physical, mental and sexual abuse.

Placement of Māori Children

[73] There were some cultural aspects relating to Maori because there was an over-representation of the Maori population in State care. About 37% of the people we saw were Maori. A large number of those were Maori men, who we saw in prison. Placement of young Maori boys in institutions often led to gang affiliations as there was a sense of family and a sense of belonging. We were told that many gangs actually began in the State institutions.

[74] The impression the Panel gained from the stories we heard, was that the Maori males were likely to be treated more harshly and put into care, especially institutions, more readily and for more trivial reasons, such as truancy. It was also common that Maori children were often placed with Pakeha foster families.

[75] Institutional practices and punishments were highlighted and in the Boys' Homes, we heard of brutal physical education regimes, packing away of clothes and parading nude, isolation and punishments. The Girls' Homes, there were assumptions made of promiscuity and girls sent to be subject to internal examinations and long days isolated in solitary units.

[2] Outlined in full at page 23 of the Report.

Our report contains a statement on page 25, that we also heard of harsh treatment in some Church-run homes; we heard from children who were abused physically, mentally and sexually by both nuns and priests.

Monitoring

[76] Relating to monitoring of the children, little priority was accorded to education. Participants reported that they were never properly transitioned into care or out of care. Any children were taken for years and then given back to their original families without warning. By the time they went home they did not know their families anymore and often were not wanted.

Abuse

[77] Physical, emotional and sexual abuse was reported to us, perpetuated by staff, caregivers, the children and their relatives, foster mothers, violence, beatings, housework, kitchen tasks, verbal abuse, and lack of affection was standard.

[78] With regard to sexual abuse, the complaints were equal across men and women. At first, we had thought that females would be reporting sexual abuse more frequently, but in fact the percentage was similar for both genders. Often, older girls were taught that they had to live with regular sexual intercourse with foster father.

[79] Another high number were punishment regimes with 730 complaints. Boys and Girls Homes seemed to support a system of institutionalised bullying and it was our opinion that very poor oversight of these children allowed abuse and neglect to occur. Overall there was a theme of violence, punishment, misplaced persons.

Social Work Failures

[80] Appendix 7 sets out examples of social work practice failure and who did this, because it was hard to understand, just from the figures, the kind of issues that were raised in respect of the social work. These are the failures seen out of the eyes of participants.

[81] People often criticised the lack of action by their social workers. It seemed there was often little, or no, social work actually done for a child.

[82] We read reports that showed at times social workers failed to follow their own policy and had knowledge that they were doing so at the time. Social work appeared to involve simply "finding a placement"; not true engagement in the lives of the children. Many participants reported that if they came home from school and found their suitcase packed, that's how they knew they would be getting a visit from their social worker and going to a new home. Sometimes decisions were made to return children home to abusive parents with no evidence that the family circumstances had improved.

[83] Participants reported that no one adult held high aspirations for them as individuals. many stories involved placements in homes at risk. These children were exposed to the risk of violence and sexual assault by adults and older children. Participants questioned the selection process. What support had been provided to the family? What was their motivation for becoming foster parents? Were social workers aware of others in the house or who visited the foster home?

[84] Very poor oversight of these children allowed abuse or neglect to occur. Many reported feeling unsafe at home but were left there with no monitoring from social workers. The Panel heard 626 people report being abused while in the care of the State. Of these, 135 had told someone at the time it happened: a social worker, a staff member or school teacher. Some were lucky enough to be moved then, but many were not. Most did not have the words or the trust in another adult to disclose what was happening to them.

[85] This common theme of social work failure was, to me, running throughout the stories of people who were taken into State care when they were very young, highlighted when they were able to bring photographs of themselves as children. There we could see a little child dressed in a viola dress, or shorts and long socks with a cap and blazer and a photograph of their grandmother, mother and father; and then hear the tragedy that had befallen them, that brought them into State care. It very confronting for us.

[86] When I started the work, there was a view in New Zealand society, that children who were in State care were in some way to blame for their plight. The participants themselves

often felt that, because they had been in a Court where the Judge framed their passing into State care around what they perceived to be their bad behaviour.

[87] For the most part, it was the adult's lack of ability to provide care for the children that resulted in them being taken by the State, or perhaps the mother had become ill, or had died and father was not coping with a large number of children, or the placement of Māori into care for trivial reasons as discussed above, showed it was very infrequent that a child's bad behaviour had brought them into care.

Psychiatric Treatment

[88] The Confidential Forum for former patients of psychiatric hospitals had already heard from many people about their experiences of psychiatric institutions in New Zealand before 1992. So what we heard echoed much of what had been reported.

[89] We heard concerns raised around consent, admission procedures, treatment, safety in hospital routines. Our distinct impression was that treatment seemed to offer no health improvements; we heard about drug treatment being given without consent, or without knowledge as to why it was being given; the use of ECT or shock treatment or deep sleep therapy; we heard of strong memories of the use of ECT as a punishment for disobedience, as well as drugs to subdue any challenge of the status quo. We also learned that young children, even at primary school age were kept in psychiatric institutions.

Legacies of Effect

[90] We were shocked to see that 413 of the persons had criminal behaviours and convictions; 320 had served prison sentences; 619 complained of difficulty forming relationships and 703 had difficulty trusting others. The impacts of State care and abuse and neglect were wide ranging and the most prevalent impacts across the Participants were anger, depression, family breakdown, difficulties with forming relationships as well as with trusting others, distrust of authority, poor education.[3]

[3] Appendix 8 of the Report outlines the legacies of effect.

[91] It was our view that New Zealand should be very concerned about the number of young people who had been in state care that later served prison sentences. It was reported to us that many could remember the time that they changed from being a scared and vulnerable child in care, to becoming a bully and a perpetrator of violence; that it was an inevitable transition in order to keep themselves safe and many men who were in jail for serious violent offending or murder, who had been abused as children, often stated that they did not have the coping skills to deal with high stress situation because of the way "their growth happened as children".

Learnings

From the Participants

[92] **Part 4** covers issues raised by the participants about improving the care system for the next generation of children. It included more direct support and social investment, hearing the voices of the children and keeping the children in care safe. We saw the need for a duty of care they would see as needed to improve things, would include a clear statement by the Government of commitment to children in care and a real and enduring care of care articulated. If the State is to take children from their families then the quality of care needs, at the very least, to be better than the home they were taken from. We believed an independent care service was essential.

Recommendations of the Report

[93] Our Panel members spent a lot of time discussing, talking and analysing what we were hearing, and how some of it could be avoided. A standout for us was the monitoring and support of children, which we believed was far from adequate and not a protective factor.

[94] The people told us that they wanted systemic change and public acknowledgement of the wrongs of the past; and at that time, they had had neither.

[95] We sought on their behalf, the recommendations that their cumulative voices called for.[4]

[96] Specifically learnt from our engagement with the prisons, we recommended a permanent confidential listening service to prisoners with beginning to lift the lid on their traumatic experiences and, in what we were able to see from our limited view of this group, be able to engage more readily with the rehabilitative measures available in the Corrections system. I cannot highlight further how important the prisoners' experiences of abuse in care is and how difficult they are to reach. It is utterly crucial that this Royal Commission engages with and records the evidence of the experience of this group.

Impact of the Report

[97] The Report was drafted with the anticipation that someone would use it to influence the behaviour of the relevant social and justice agencies in the future.

[98] The Service was closed for reasons that were not explained to me, but I understand that the Departments of Education and Health had dealt with most of their claims and it was decided that the Ministry of Social Development would prefer to deal with matters inhouse.

[99] Following the close of the Service, I personally did raise the matter on one or two occasions with the Chief Social Worker. I ascertained that at that point none of the material from the Report had been used in any practical way to influence future behaviour.

[100] We lodged the report with the Ministers, and a meeting was held with the Minister of Social Development. She had Paula Rebstock's report underway and expressed her wish that the report be given to Paula Rebstock, which did occur, and we met with Paula Rebstock to discuss various issues that were relevant.

[101] It was not until 8 September 2016 that a Government response was written to the Cabinet Social Policy Committee detailing a response to the report. That report was written by the Ministry of Social Development and contained some matters of concern to me as Chair.

[4] Part 6: Clauses 1 to 7 of the Report.

[102] Noting that the Service was administered by the Department of Internal Affairs, it was our expectation that the Report would be received by the Minister of Internal Affairs and reported on to either the Prime Minister directly, to maintain the independence originally intended in 2007, and most importantly, that the participants needed to be thanked, and a n acknowledgement in the very least that the issues raised were serious and deserving of a response.

[103] That the Ministry of Social Development was given a platform to respond and provide commentary about the Service directly to the Cabinet Social Policy Committee from a defensive position was incredibly dismissive of the experience of the participants.

[104] The response was not received by me until sometime later when I was overseas and a day before it was released into the public arena.

[105] In relation to our recommendation for an apology, Clause 10 said:

> *"The Service recommends a public statement to the people of New Zealand acknowledging those who suffered abuse in care. This recommendation is not supported on the basis that the Government considers that the majority of children in care did not suffer abuse, so a universal apology is not warranted. However, apologies are made to individual claimants whose claims are accepted".*

[106] The use of the words "not warranted" was harsh and there is no acknowledgement thanking the people that came forward at the invitation of the Government for their courage in so doing.

[107] Clause 33 said:

> *"Across the sectors, there is no evidence that the care systems were universally broken. Some people who have made claims had periods of positive caregiving environments as well as abusive experiences. The majority of children and young people in care had positive experiences*

with no abuse or neglect. The number of claims received by the Ministry of Social Development compared with the total number of children placed in State care suggests that approximately 3.5% of children in care may have been abused or neglected in some way. That has occurred across all types of care – residential, foster, family/whanau and community provider."

[108] Some people who have made claims had periods of positive caregiving environments as well as abusive experiences. There is an inference to be drawn that is acceptable. They state that 3.5% in care may have been abused, which, regardless of the accuracy of that number, would still be large numbers of children. This figure was utter conjecture as no study as to the extent of this was ever undertaken. My understanding is that the Ministry was using the figures from the numbers of claims laid at that point.

Aspirations for the Royal Commission

[109] I hope that staff at the Royal Commission are aware of the potential trauma for participants of the Service who decide to re-engaging with another process and that they take due care when encouraging evidence and engagement. These participants have already provided so much. Their bravery and courage in coming forward for the Service was remarkable.

[110] In my view it is crucial to consider in detail the practices and policies of the social services agencies working with children in care, particularly with regard to systemic failures. The Service was unable to investigate these policies and practices. There must be a comprehensive assessment of the system in place which at present appears invisible from external assessment.

[111] I would expect the Royal Commission to speak directly to staff who have worked there over the years and who are willing to share their wealth of knowledge of the systemic issues.

[112] At the time of the closure of the Service, I did not think that a Royal Commission with wide-ranging investigative powers would be necessary as it appeared evident that a detailed

investigation of the care system would be a logical follow-up given the Report's findings. However, the Ministry or Department's response to the Report was as shocking as it was dismissive of the voices of the victims of those who had been abused in State care. I was disheartened by the fact that the Cabinet committee accepted the response without reservation, and to my understanding not much progress was made with our recommendations.

[113] I believe there are many very dedicated people working to achieve the best care for children in New Zealand. Occasionally, over the years I have encountered an attitude through to the highest levels within social service agencies that there is little wrong with the present structures, that they know best, and that actual or risk of harm is minimal. The way the systems are set up contribute to this issue and common sense does not prevail. Maybe financial considerations are the driver. To that end, I consider the Royal Commission's assessment of the social services industry, the policies, practices and attitudes therein, to be essential.

[114] It is likewise important for the Royal Commission to look at the systems of accountability that currently exist and might be made more robust.

[115] Finally, I will close with a recitation the poem that was given to the panel in Christchurch 2012 and sent to the Prime Minister on behalf of one of our participants, which sums up the feeling that many of these people had as a result of their lifetime in State care:

"A Letter to the System"

To whom it may concern,
To the one without a face or a name,
Here's a letter from a 'ward' of yours
Who carries your whole system's shame.

You pulled me from parents
This I accept and I understand,
But while I was taking this journey,
Who was there to hold my hand?

I was told that I 'belonged' to you,
It was your job to watch me grow,
But I don't think you were able to 'see' me,
With so much moving to and fro.

I was quiet and shy and unsocial,
Distrusting everyone as I grew
You were blind to all that bruises them,
Please don't be bland to the scars now too.

In your care I learnt my value,
I learnt my lesson, my worth, my place,
In short I learnt I was not a child
But simply another hopeless case.

Your 'carers' stole my childhood,
He with his dirty old man hands,
And her leather belt and punches,
No one caring where I land.

So, I write this letter to you
And ask that you take some blame,
But I cannot sign it 'sincerely'
When you left me with so much pain.

Signed:

Date: