IN THE ROYAL COMMISSION OF INQUIRY INTO HISTORIAL ABUSE IN STATE CARE

UNDER	The Inquiries Act 2013
AND	
IN THE MATTER OF	To inquire into and report upon responses by institutions to instances and allegations of Historical Abuse in State Care between 1950 and 2000.

BRIEF OF EVIDENCE OF SONJA COOPER AND AMANDA HILL ON BEHALF OF COOPER LEGAL

Dated: 5 September 2019

Cooper Legal
Barristers and Solicitors
Level 1, Gleneagles Building
69-71 The Terrace
PO Box 10 899
Wellington

Phone: (04) 499 9025
Email: Sonja@smcooperlaw.co.nz

BRIEF OF EVIDENCE OF SONJA COOPER AND AMANDA HILL ON BEHALF OF COOPER LEGAL

1. Thank you for the opportunity to be heard today. Cooper Legal is a small law firm based in Wellington. Our core work is helping people make civil claims against State agencies and faith-based institutions for abuse they suffered in care as children or vulnerable adults. In the course of our evidence, we will talk about:

    (a) The beginnings of the civil claims against the State for abuse in psychiatric hospitals and Social Welfare care;

    (b) How the claims grew, and how the State responded – with a mixture of 'listening' forums and fierce, uncompromising defence in the Court;

    (c) How State mechanisms such the Courts and Legal Aid played a role in the claims process;

    (d) The role of our human rights law – both national and international – in progressing the civil claims;

    (e) Settlement processes both past and current, and why they are not fit for purpose; and

    (f) The disadvantages experienced by many survivors, including: less access to information; fewer resources to obtain help; often poor literacy or mental health and economic circumstances which pressure them to accept amounts of compensation which do not reflect their experiences; and

    (g) What we see as the way forward for the claims process as part of a larger truth and reconciliation process.

2. We first want to address the language we will use in our evidence. We often speak about victims of abuse, but we want to talk about the people we have met in our work in a way which empowers them. We will use the terms survivors, ngā mōrehu, or care leavers, to talk about people who have experienced abuse in care.

3. We want to place people who were in care at the centre of what we do, but we know that every experience is different, and just as survivors cannot speak with one voice, we cannot speak to all their experiences. We acknowledge the care leavers who will speak to you over the life of the Commission. We cannot stand in their shoes.

4. We will talk a lot about "civil claims". These are claims in tort or under human rights legislation, mainly against government departments

which were responsible for the care of children and vulnerable adults. They are mostly directed to the government because it is liable for the actions of people it employed or contracted to do its work. We also work on claims against faith-based organisations and other organisations which provide services to children and vulnerable adults. We do not take claims against individual government employees, or work in the criminal jurisdiction.

5. We will also use abbreviations to describe the main defendants to civil claims for abuse in care. The State will often refer to itself as the Crown, which suggests a single entity, but the responses by different parts of the Crown to these claims have been very different. There is no single Crown response to abuse in care.

6. The Ministry of Social Development, or MSD, is the government department responsible for almost all civil claims for abuse in the care of Child Welfare (as it was known up until 1972), Social Welfare (1972 – 1989) and Child, Youth and Family Services, or CYFS, which was the entity caring for children up until the creation of Oranga Tamariki in April 2017[1].

7. Oranga Tamariki has said it will respond to claims by people who were in care after 2008. However, it has no process to do that yet and we still direct all claims to MSD, because Oranga Tamariki did not exist when most survivors were in care. Sadly, Oranga Tamariki will be a defendant in its own right eventually, as survivors continue to come forward.

8. The Ministry of Education (MOE) and the Ministry of Health (MOH) are the other two main defendants.

9. MOE deals with civil claims by people who were abused in some State or special residential schools. Waimokoia, McKenzie School and Salisbury School are just some examples. Sometimes, MOE is jointly responsible for a claim. For example, Campbell Park School (also known as Otekaike), near Oamaru, was run by people who were employed by both MOE and MSD.

10. MOH responds to claims about abuse in psychiatric hospitals, such as Porirua Hospital, Kingseat and Lake Alice where that abuse happened prior to 1993[2]. MOH has, very recently, said that it will also deal with claims of abuse in general hospitals, which occurred prior to 1993.

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[1] The 1990s saw a lot of variation on CYFS, including CYPS and CYPFA. We will just talk about CYFS.

[2] MOH defines "historic" experiences as being prior to the introduction of the Mental Health Act 1992.

Who do we represent?

11. Currently, we have around 1250 clients and about 1400 open files. This difference reflects that some people have multiple claims – for example, one claim against MSD for abuse in Social Welfare or CYFS placements, and another against MOE for abuse in residential schools.

12. The clients of Cooper Legal vary in age from 18 to 80. The claims cover the period from the 1950s through to the present time, although the majority of claims are for abuse which occurred during the 1970s and 1980s. However, the number of clients born after 1980 continues to grow.

13. Of our client group, approximately 17 are under the age of 22. Approximately 135 clients are under the age of thirty and around 300 clients were in care after 1999.

14. We estimate we have settled around 1100 claims against MSD, MOE and MOH, as well as faith-based organisations. To date, our clients have been paid settlements totalling $22,775,000, which includes a contribution to legal costs. While no amount of money can heal some wounds, we would say that no survivor has received adequate compensation for the harm done to them.

15. Of course, these figures will not include payments made to self-represented claimants. Only the State and churches involved can provide that information.

16. Most of our clients are vulnerable in some way. Many are beneficiaries or low wage earners in precarious economic positions. Around 40% are in prison at any given time. Almost all experience mental distress or ongoing effects from the events in their childhood. Our clients are disproportionately Māori.

WHAT "STATE CARE" MEANS

Legal Status

17. In our work, we talk a lot about the 'legal status' of a person who was in care. Their legal status defined their relationship with the State, and how they could be treated.

Being "under notice" or on preventive supervision

18. Many children came under the purview of Social Welfare while they still lived at home. Sometimes this was due to notification of abuse or neglect, or poverty, or because a child had committed offences. Many

Māori children were prosecuted for the misdemeanour of stealing milk money. Many Pākehā children, were not.

19. The Courts have held that, if Social Welfare received a notification of concern about a child, such as physical or sexual abuse, a duty of care arose between Social Welfare and the child to investigate it[3].

20. Preventive supervision was an administrative mechanism developed by Social Welfare to prevent children becoming "casualties". It often involved regular visits by social workers, emergency financial assistance and visits to a child's school.[4]

21. Preventive supervision was different to legal supervision. Legal supervision was imposed by a court, often in response to a child not being properly supervised by their parents, or for offending.

22. At times, Social Welfare received reports or notifications of concern about a child, and failed to act. Sometimes, the reports piled up, particularly about abuse in the home environment, and still nothing happened. This is still a major problem today. In contrast, other children (particularly Māori children) were removed from their families, sometimes for years, for the simple crime of being poor.

Complaints

23. Many children came into care by way of "complaint action" – that is, a complaint by Social Welfare or the Police that a child was not under proper control, or that a child was living in a detrimental environment. This would often pave the way for a child to be placed under the guardianship of the Director-General of Social Welfare.

Remand / Adjournment

24. Much like an adult, a child could be remanded in care while a complaint was investigated or to allow a social worker to report to a court.

Voluntary Placement in Care

25. A child could be placed under a voluntary agreement for care by their parents.[5] These agreements were often for a month, a year, or sometimes even two years.

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[3] *B v Attorney-General* [2003] UKPC 61; [2004] 3 NZLR 145 (PC) [Cooper Legal's Bundle, Vol. 1, tab 2] and *Attorney-General v Prince & Gardner* [1998] 1 NZLR 262 (CA) [Cooper Legal's Bundle, Vol. 1, tab 1].

[4] *White v Attorney-General* HC Wellington CIV-1999-485-85, 28 November 2007, Miller J at [52] [Cooper Legal's Bundle, Vol. 2, tab 11].

[5] Sections 11 and 12 of the Children and Young Persons Act 1974.

26. Other than the use of Secure Units, which we will deal with later, a child under a voluntary agreement could be placed in Family Homes, institutions, or foster care in the same way as a State Ward.

State Ward

27. A child who was put in the custody and guardianship of Social Welfare was commonly referred to as a State Ward, until the introduction of the 1989 Act. Being a State Ward meant that Social Welfare had total control over a child's life. Social Welfare controlled where a child could live, where they could go to school, where they could work (when they got older) and how much money they were able to get. A person was usually discharged from guardianship at the age of 17 but could remain a State Ward until they were 20 in some circumstances.

28. Many children who were under the care or custody of Social Welfare were placed in faith-based institutions. Sometimes, the line of responsibility is difficult to draw.

After 1989 – A Whole New Scheme

29. There are plenty of historians and sociologists who will speak to the changes in the 1980's that brought about the Children, Young Persons, and Their Families Act 1989, which we will refer to as the 1989 Act.[6] The 1989 Act was a drastic departure from the earlier Children and Young Persons Act 1974. It brought in a whole new language and a whole new scheme for child welfare in New Zealand. It separated, some would say arbitrarily, "Care and Protection" cases from "Youth Justice" cases. In our experience, the two are typically intertwined.

30. The 1989 Act provided a scheme for the Family Court to deal with Care and Protection issues, with the ability to place a child under the custody and/or guardianship of what became known as CYFS. Youth Justice provisions mainly dealt with children between the ages of 14 and 16 years old who had committed offences. However, the 1989 Act continues to criminalise younger children in some circumstances.

31. Decisions were made by Family Group Conferences, often called FGCs, which make plans for children and young people. The plans had a range of activities and a range of outcomes. Children and young people could be sent to programmes or put in care under an FGC plan, without ever going to a court. Some plans meant that if a young person completed tasks such as community work, the charges were considered to be dealt with and the young person received a clean slate. That process continues. The Youth Court can impose a range

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[6] See, for example, *Family Matters: Child Welfare in Twentieth-Century New Zealand,* Bronwyn Dally, chapter 7. See also *Pūao-Te-Atatū (Day Break), the report of the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare*, September 1988.

of orders, ranging from admonishing a young person, community work orders, supervision with activity orders, and supervision with residence orders. The latter two orders were often for 3 months, and were usually followed by a six-month supervision order, where a child or young person had to live where directed, undertake various programmes and tasks, and would be under the direct supervision of a social worker.

32. While the 1989 Act was considered to be world-leading and extremely progressive, social workers took some time to catch up. In our experience, children who were in care in the transitional period between the late 1980's and the first few years of the 1990's fell through the gaps as social workers struggled to adjust, and resources were not available to implement parts of the 1989 Act. Almost always, people who were in care at this time have incomplete and inadequate records. Important aspects such as FGCs, were not used properly.

33. Another important change occurred shortly after the 1989 Act was introduced. The New Zealand Bill of Rights Act 1990 came into force on 25 September 1990. From that date, children in care had additional rights, and the State had additional responsibilities, which overlaid the 1989 Act. We will talk more about the Bill of Rights Act later in our evidence.

The s396 Approval Scheme

34. The 1989 Act formalised a process where Social Welfare, now CYFS, used third party programmes or organisations to care for children. Under the 1989 Act, programmes or organisations had to meet a number of requirements before they could be contracted, and paid, to care for children who were under the custody or guardianship of CYFS. The scheme also provided for complaints to be investigated and the approval of an organisation suspended or cancelled, if necessary.

35. While this sounded good in theory, the practice sometimes went horribly wrong. The division between 'front line' social workers and the Community Funding Agency created different measures of expectation. Complaints were not properly investigated and, even when complaints were substantiated, programmes continued to be used to care for children. Further abuse was the inevitable result. We will talk more about the Whakapakari Programme, the Heretaunga Māori Executive and Moerangi Treks later in our evidence.

36. The use of these kind of organisations has, at times, caused MSD to say it is not responsible or liable for the things that happened to people on these programmes. This is even where the children or young people were in the custody or under the supervision of CYFS, and where CYFS approved the programmes. Some survivors have been

denied a remedy, and when MSD changed its position, they were unable to reopen their claims.

Faith-based Institutions

37. The experiences of people placed in faith-based institutions were often very different from State care experiences.

38. Very young children were sometimes placed in orphanages or foster homes run by faith-based institutions. Some examples of this were The Nest, a home in Hamilton run by the Salvation Army, or Catholic-run orphanages such as the Star of the Sea, or the Home of Compassion.

39. Under the Infants Act 1908, anyone taking a child under the age of 6 into care had to be licensed as a foster parent.[7] Under the Child Welfare Act 1925 children could be detained in an "institution" which included some private institutions.[8]

40. Sibling groups were placed in Whatman Home in Masterton or the Bramwell Booth Home in Temuka, which were run by the Salvation Army. The Salvation Army also ran Hodderville, a home for boys in Putaruru. In Auckland, the Anglican Trust for Women and Children ran Brett Home, Stoddard House and smaller cottage-style institutions. The Anglican Diocese of Waiapu ran Abbotsford Home in Waipukurau, which operated for many years. A large number of State Wards were placed in these homes. Families also placed children there privately, paying maintenance if they were able.

41. When a child or young person was placed in a faith-based institution by Social Welfare, board was paid to the institution for the care of the child. Social workers were supposed to visit regularly, although this often fell by the wayside, particularly when the homes were remote, such as Hodderville.

Legal Status – Psychiatric Hospitals

42. Patients were admitted to psychiatric hospitals as voluntary boarders/ informal patients and committed patients, under the relevant mental health legislation. Patients could also be admitted under the Criminal Justice Act. Informal patients had the right to refuse medical treatment.

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[7] s41 of the Infants Act 1908. An institution supported wholly or in part by the Crown could be exempted from having to hold a license.

[8] s12 and s15 of the Child Welfare Act together with schedule 1.

THE EXPERIENCES OF CHILDREN AND ADULTS IN PSYCHIATRIC CARE

43. By far the most common complaints made by claimants were of:

    a) severe physical assaults at the hands of staff and other patients, including punching, kicking and hitting; and/or

    b) sexual violation and abuse from staff; and/or

    c) administration of unmodified ECT or ECT as a punishment; and/or

    d) being placed in the ECT room to frighten them into submission; and/or

    e) administration of paraldehyde injections as a punishment; and/or

    f) placement in seclusion and psychiatric criminal wards as a punishment or in order to induce compliance in patients who "misbehaved".

44. Other claimants complained of traumatic incidents such as: being hosed down by the nursing staff; being threatened with a lobotomy; and being told that they would never leave the hospitals.

45. A significant proportion of claimants spent long periods of time being locked up in seclusion in inhumane conditions, which included being deprived of toileting facilities.

46. For example, W recalls:

> ..it was common to get clouts, kicks up the bottom, verbal abuse and threats of ECT from nursing staff. This would also happen if I didn't do my jobs properly, like polish the floors. It was just an everyday experience to witness staff physically abusing patients.

47. We also acknowledge Beverly Wardle-Jackson, who will give evidence about her experience at Porirua Hospital.

THE EXPERIENCES OF CHILDREN IN SOCIAL WELFARE AND CYFS CARE

48. It is impossible for us to summarise the vast array of experiences that children and young people, and vulnerable adults, had in State care. The accounts which we will set out for you are merely examples to demonstrate what happened to entire generations of people placed in the care of the State. We have tried to reflect the range of experiences, and demographics, of our client group. If we omit to talk

about an institution or a placement, it is not because it did not happen. All experiences that these survivors will bring to you are equally valid.

Family Homes and foster placements

49. Social Welfare Family Homes were spread all around the country. The house parents often varied, although some remained house parents for years. The idea behind a Family Home was, as the name suggested, five or six children living in an environment intended to be family-like. Many experiences relayed to us from our clients about Family Homes reflect that the parents were well-meaning but did not have the tools or skills to cope with groups of difficult children. There was no night time supervision, and so physical and sexual abuse between children was a regular feature of stays in Family Homes. The abilities of the Family Home parents varied greatly, with some receiving very positive reports from care leavers and others having a long history of violence. A number of Family Home caregivers are the subject of allegations of physical or sexual abuse.

50. It was often common to see the grown children of Family Home caregivers acting as relieving caregivers or, in many cases, acting as enforcers of the rules of the home. Clients often tell us that the grown sons of Family Home or foster caregivers would be the ones dishing out violence to bring the residents into line.

51. With foster care, as with any situation, there are many foster parents who are spoken about with appreciation and admiration by our clients. Unfortunately, long stays at good foster homes were rare. Like many foster children, and many who are in care today, children in the foster care system experienced multiple placements, impacting their ability to settle, adjust at school, and feel safe and secure.

52. Many clients talk about physical and sexual abuse at the hands of foster parents. A common theme in their reports is that any attempt to disclose this to their social workers or other people were met with disbelief, or punishment for lying. It was exceptionally rare for a child to be believed, and for action to be taken. Usually, action was only taken if a second person, usually not a child, could corroborate their account. More often than not, complaints went unheeded and the abuse continued.

Social Welfare and CYFS residences

53. Boys' and Girls' Homes were spread throughout the country. Some operated as remand homes, like Lookout Point, Stanmore, Owairaka or Epuni. Others were national long-term training institutions. The most well-known of these were Hokio Beach School and Kohitere.

54. Several staff members from different institutions have been convicted of sexual abuse against children. A list of those people who are known to us as having been convicted is **attached** to this brief as Appendix "**A**". It is by no means complete.

55. However, these convictions only tell one part of a wider story. All too often, staff members who were found to be abusing children were permitted to resign from their positions without referral to the police, or, worse, were shifted to another institution.

56. Sometimes, after a period of "purgatory" those staff members were even promoted.

57. One example is Mr S, a staff member at Campbell Park School. In January 1970, S, an instructor, was suspended pending investigation of allegations of sexual abuse against three different boys at Campbell Park between March and August 1969. Subsequent records note:

    a) S had taken the boys to his home on multiple occasions, sometimes during the evening when his wife was not home;

    b) A rubber penis had been found concealed in the ceiling of his home;

    c) A train set was used as an inducement to take boys to his home;

    d) Mr S showed the boys pornography and paid one of the boys for a photo of his sister;

    e) Mr S denied the offences;

    f) Mr S told Mr Walsh that, a number of years earlier, another boy had made allegations of sexual abuse against him, but Mr Connor (the then Principal) had not believed him;

    g) The Police declined to press charges, believing the boys would not do well under cross-examination;

    h) Mr S subsequently resigned from Campbell Park.

58. In 1979, as part of a Human Rights Commission Inquiry into Social Welfare Institutions, Ken Cutforth complained to the Human Rights Commissioner that several staff members had been shifted or promoted after allegations had been made against them. Mr Cutforth had previously worked at Kohitere and Hokio.

59. We are aware that Oliver Sutherland and his colleagues from the Auckland Committee on Racism and Discrimination (ACORD) will

speak to these matters, so we touch on them only briefly. These documents show that Mr Zygadlo[9] had been shifted from his post as Principal of the Margaret Street Girls' Home in Palmerston North following an alleged indiscretion with an inmate. He was later promoted to Principal of a Boys' Home after spending a number of years at Hokio. In early 1978, Mr Cutforth said, the Principal of Bollard Avenue Girls' Home was hurriedly transferred to Holdsworth School. This was based on alleged misconduct with an inmate who had been transferred to another residence. He was later promoted to the Principal of Holdsworth.

60. Mr Jack Drake was another staff member who had a multitude of allegations brought against him. We have gathered information about his movements over several years.

61. Mr Drake began working for Social Welfare in September 1958. He was a General Attendant at Hokio Beach School in Levin. He was later promoted and transferred to Owairaka for 2 years as a Housemaster. He also worked at Hokio for four years, and then shifted to Campbell Park.

62. In 1971 Mr Drake was again promoted and transferred to Holdsworth School as Assistant Principal, under Mr Powierza. After Mr Powierza was transferred to Auckland, Mr Drake was the Acting Principal for a few months until Michael Doolan was appointed as Principal in late 1975. Mr Drake remained at Holdsworth until he resigned from the Department.

63. During the time that Mr Drake was the Acting Principal of Holdsworth, there was an investigation into allegations that Mr Drake had been sexually abusing boys. The investigation was done by the controller of national institutions, Denis Reilly. The documented outcome of the complaint or nature of it, if it was ever documented, has never been found.

64. In an inspection report of Holdsworth, dated 10-12 March 1975, it was recorded that Mr Drake "now … keeps his distance from the boys and this affects both his work and his job satisfaction".

65. The allegations against Mr Drake were raised again in July 2004 by a client of Cooper Legal. Three years later, a team from MSD and Crown Law interviewed Mr Drake. In the same year, a police complaint was laid. At around the same time, MSD advised the police that five other former students of Holdsworth had made allegations against him. The police took nearly a year to interview other staff members from Holdsworth, some of whom had concerns about his behaviour towards boys. The police only spoke to Mr Drake in April

[9] Mr Zygadlo and Mr Drake are both deceased.

2009, by which time he was judged too unwell to make a statement. However, he was well enough to swear an affidavit for MSD a few months later.

66. In the course of settling historic claims, MSD has accepted allegations of sexual abuse by Mr Drake, although only where those allegations have been of lower level sexual assaults. MSD has not accepted allegations of rape by Mr Drake, despite the weight of evidence being against him.

67. At Hokio, complaints of sexual abuse by the cook, Michael Ansell, were ignored. Had a police check been done prior to hiring him, it would have revealed that Michael Ansell had convictions for sexual abuse in 1969, prior to his time at Hokio. Michael Ansell was eventually convicted of indecently assaulting boys at Hokio, abuse which could have been prevented entirely.[10] Another staff member, MT, was disciplined for assaulting boys and dismissed after he was charged for sexually abusing boys at Hokio. Each time, police involvement was a last resort, not a first response, by the management of Hokio or their superiors in the National Office.

68. These are only some examples of staff being shifted or complaints not being dealt with properly, which exposed vulnerable children to further abuse. It also reflects the very long time that the police would take to investigate historic claims, because they were not deemed as important or as urgent as other cases.

69. Other assaults took more insidious form, under the cover of medical examinations. The visiting doctor servicing Wesleydale and Owairaka Boys' Homes was well known amongst the boys. This was because he would line up boys in the institutions, or examine them individually, by removing their clothing and touching their testicles. The boys referred to him as "Dr Cough". These medical examinations were completely unnecessary but carried out with regularity over a number of years.

70. We also highlight the issue of internal vaginal examinations conducted on residents at Girls' Homes throughout the country. In particular, Bollard Girls' Home and Allendale Girls' Home conducted internal examinations, purportedly to establish whether a girl had venereal disease. Girls who refused to undergo the examination were severely punished. This is covered by a complaint by ACORD in February 1979.[11]

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[10] Findings were also made that Mr Ansell had sexually abused one of the plaintiffs in the High Court trial in *White v Attorney-General CIV-1999-485-85* (HC) Wellington 28 November 2007, Miller J. The convictions of Mr Ansell related to boys at Hokio. See [239], [306]-[312] of this decision, which also deals with MT. Michael Ansell is deceased.

[11] See Bronwyn Dally's book, *Family Matters,* page 301-304.

71. We also note that in recent correspondence regarding a female client's claim, MSD refused to accept an allegation that she had been improperly vaginally examined at the age of 9 years old, saying that that action was within policy.[12]

Culture of violence

72. A more pervasive matter at most institutions around the country was an ongoing culture of violence, coupled with an environment which prohibited "narking" or "snitching". This culture of violence perpetuated itself in a number of ways. This included:

a) "Welcoming" or "initiation" beatings. These occurred at virtually every residence in the country. A new admission to a residence was subjected to a beating by the other residents, sometimes away from the eyes of staff, and sometimes with staff looking on. At Hokio, initiation beatings took place over in the sand dunes, where no staff members were present. At some institutions, initiation beatings occurred at night time in the dormitories, where a pillow was held over a new resident's face while they were repeatedly punched and kicked or hit with items. At Kohitere, beatings were done with steel-capped boots, from boys who were old enough to work or who were taking part in the work training programmes;

b) Initiation beatings, and the regular violence which followed many residents at institutions, were enabled by a Kingpin hierarchy which was encouraged and permitted by staff members. A Kingpin was usually the strongest or largest boy or girl. They often perpetrated violence on younger children at the direction of staff members, who would use the Kingpin as a form of discipline, while providing the Kingpin favours and privileges not afforded to other children. There is even a movie called *Kingpin*, made with boys who were being held at Kohitere at the time;[13]

c) Kingpin hierarchies have existed in one form or another in most placements and programmes. Some were formalised, such as at Whakapakari on Great Barrier Island. Senior boys were referred to as the "Flying Squad" and their job was to chase down absconders and beat them before returning them to the main camp. Flying Squad members also were left on a small island known as Alcatraz with absconders, with the task of repeatedly beating them as punishment. The next tier of boys were known as "Junior Leaders". These phrases were regularly used in correspondence between the management of Whakapakari and CYFS staff members. They have occasionally

[12] MSD responses to Cooper Legal client claims.

[13] *Kingpin* was the second of a trilogy of films from Mike Walker, Morrow Productions. It can be viewed along with the other two movies, *Kingi's Story* and *Mark II* on the NZ Onscreen website.

been described by Whakapakari staff members as “tribal policemen”;

d) It was commonly understood through actions and words that if children disclosed abuse, they would be further punished or targeted for being a “nark”. This environment was perpetuated for so many years that it can be clearly seen within our prison system now. A recent report on CYFS residences reported that this environment still exists, using the phrase “snitches get stitches”.[14]

Psychological Abuse

73. For some claimants, although they endured horrific and prolonged physical and sexual assaults, it is the psychological and emotional abuse they suffered which caused them as much, or more, harm. These children were told: that they were useless; they would end up in prison; that they would never amount to anything; that their parents did not love them and that nobody wanted them; that they were worthless; and that nobody cared what happened to them.

74. The psychological abuse perpetrated by staff members has had a long-term effect on many survivors. These were children who lived in isolation from society and whose role models in the institutions were adult staff members. Survivors describe that after they were constantly taunted and told by staff members that they were worthless, they eventually began to believe that they were worthless and stopped caring or feeling. They often developed strong anti-social tendencies and turned to groups of children within the institutions, and later gangs, for their support.

Solitary confinement

75. A significant part of the institutional life for many residents was the use of a Secure Unit. Most remand centres and all national institutions had Secure Units of some sort. Largely, being placed in a Secure Unit involved 23 hours a day of isolation, punctuated by excessive physical training, which was in turn punctuated by physical abuse from staff members. Some children were placed in the Secure Unit as a matter of course when they were admitted to an institution. This was later found to be a breach of policy. Others were left in the Secure Unit for weeks on end, one boy spent a total of 99 days in one stretch at the Secure Unit in Owairaka.[15]

76. The Children and Young Persons (Residential Care) Regulations 1986 came into force on 1 November 1986. It was intended that,

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[14] *State of Care 2017: A Focus on Oranga Tamariki's Secure Residences,* report by the Office of the Children's Commissioner.

[15] Claim by MM, now settled.

among other things, the Regulations would provide more structure to the use of Secure Units. These Regulations required daily reviews of a placement in Secure, that education opportunities be provided and that a young person should not be regularly confined to their room. In our experience, these Regulations, in the first few years at least, were largely ignored.

77. Importantly, if a child was placed in an institution under a voluntary custody agreement, they could not be forcibly detained in a Secure Unit. Unfortunately, this was not clear for a number of years and many children were unlawfully imprisoned.

78. This was only clarified when a document was sent out to the institutions on 23 February 1987[16]. The document confirmed there was no legal basis to detain children in Secure, who were at Social Welfare institutions under a voluntary agreement – a practice that had been occurring since 1983, when legislation allowing for the detention of children in Secure care had been enacted.

79. The document also confirmed that children who were admitted to the institutions on a temporary or informal basis, under a warrant, or under the Criminal Justice Act, also could not be kept in Secure care.

80. Prior to 1983, there was no specific legislative provision allowing for Secure care, at all.

81. Research has shown the damaging effect of solitary confinement, particularly on young or vulnerable people.[17] Notably, this report also deals with the use of seclusion in mental health institutions.

Practice Failures

82. Social workers and State agents were governed by practices, policies and manuals in their day-to-day work. The failures by social workers or residential staff members to comply with these guidelines are commonly called practice failures, and they are a significant part of civil claims. Practice failures only come to light on a close examination of a survivor's individual records, and so they risk being overlooked by the Commission. **However, understanding practice failures is vital.** Examples of practice failures include:

    (a) the failure to properly investigate complaints of abuse by young people or others, leading to further abuse;

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[16] We are unable to provide the Commission with a copy of this document, as it was provided to us under a discovery order.

[17] *Thinking outside the box? A review of seclusion and restraint practices In New Zealand,* Dr Sharon Shalev, April 2017 [Cooper Legal's Bundle, Vol. 2, tab 15].

(b) accepting that abuse has occurred, but leaving a child or young person in the same placement;

(c) the failure to do police checks or background checks on caregivers;

(d) the failure to refer criminal behaviour by caregivers to police;

(e) the failure to visit a child in care regularly, and speak to them alone when they are visited;

(f) the failure to keep adequate records;

(g) the failure to ensure that a child who is in the custody or care of the State is attending school; and

(h) the failure to properly support placements, in particular, placements with whānau.

83. So often, practice failures caused enormous harm to children and young people. In our work, we have seen an enormous number of cases where a young person is the subject of notification after notification of concern, often at home, and nothing is done. Sometimes, the social worker responsible spoke to the alleged abusers, but not the child. Sometimes, the child was not believed and left in the placement to suffer further abuse.

84. Practice failures are measured against the policies and procedures of the day, so they are constantly changing. However, they must not be overlooked if the Commission is committed to understanding how abuse occurred.

Third-Party Caregivers and Programmes

85. Under the 1989 Act, organisations such as the Youthlink Family Trust and the Open Home Foundation were approved as caregivers. CYFS could place children in the care of those organisations. However, we have always said that the State retained responsibility for those children, because, in most cases, the placement of children did not change the custody or guardianship arrangements in place.

86. The approval scheme and the ability to provide care or programmes for children in a particular area, or in accordance with a particular kaupapa, gave rise to a plethora of programmes and organisations, often set up as small incorporated societies and completely reliant on the funding provided by CYFS.

87. Some of these organisations still exist today. We acknowledge organisations like START Taranaki and Challenge 2000, who provide

invaluable assistance and support to tamariki. On the other hand, we note that other organisations have shut down and restarted under different names, to avoid litigation over abuse claims.

88. Throughout the 1990s and into the 2000s, a number of programmes were utilised by CYFS for young people, in particular young Māori men, who were regarded as too difficult to place anywhere else. These programmes had common traits. They were often run by a single charismatic man, who had total control over the organisation. They were often in remote places and were not regularly visited or monitored by CYFS.

89. An example of this is the Whakapakari Programme. Run on Great Barrier Island, it began as a programme under the auspices of the Department of Māori Affairs. It later became a place where CYFS put young men and, up until 1995, young women. The environment was harsh, and the supervisors were untrained. From as early as 1994, complaints were made about physical and sexual abuse, the harsh environment, and the use of a small island known as Alcatraz, as a form of punishment. Despite multiple complaints, the Whakapakari Programme was propped up by CYFS because it was considered to be one of the few places that would still take the most difficult young people in CYFS care. The safety and wellbeing of young people came second to the support for a programme which was clearly deeply flawed.

90. Programmes known as Moerangi Treks and the Eastland Youth Rescue Trust, which were run in remote locations, also have a horrific history of violence associated with them. The approval scheme completely failed young people placed on these programmes.

91. Moerangi Treks was the subject of multiple complaints throughout the 1990s and, eventually, young people were withdrawn from it. One of the staff members under investigation at Moerangi Treks was permitted to open the Eastland Youth Rescue Trust, on the same property and with the same programme, almost as soon as Moerangi Treks closed down. The Eastland Youth Rescue Trust, as it was called, lasted a year before allegations of boys being chained up, having guns fired at them, and being severely beaten came to light. If the approval scheme had worked properly, Moerangi Treks would have been more closely monitored and shut down sooner, and the Eastland Youth Rescue Trust would not have come into existence at all.

92. A more recent example is the Heretaunga Maori Executive, which ran up until 2010 despite a litany of complaints and convictions of caregivers.

93. A summary of complaints about Whakapakari, Moerangi Treks, Eastland Youth Rescue Trust and the Heretaunga Maori Executive is attached as **Appendix B**

RESIDENTIAL SPECIAL SCHOOLS: MOE

94. Residential special schools were spread all around the country. Many have now closed, and many have had different names over the years. MOE is answerable for abuse suffered by children in these institutions. One example of a residential special school where many children suffered abuse is Waimokoia School.

95. We have seen a wealth of material regarding Waimokoia School, much of which has been provided under High Court discovery orders by MOE. While we cannot provide this material to the Commission, we can speak generally about our clients' experiences at Waimokoia and we can refer to material we have received through Official Information Act requests or other publicly available resources.

96. Waimokoia was first known as Mt Wellington Residential School. In January 1980, the school moved its premises to Bucklands Beach, where it was known briefly as Bucklands Beach Residential School, before being renamed Waimokoia School.

97. Unlike schools like Campbell Park which were designed for children with intellectual disabilities, Waimokoia was set up to cater for children who exhibited serious maladjustment, as it was described, over a long period. The children who went to the school were aged between 7 and 13. While both boys and girls were enrolled throughout the school's history, male students always outnumbered the female students.

98. People who lived at Waimokoia from the 1970s through to the 2000s have complained of: sexual and physical abuse by staff; sexual and physical abuse between residents, which often went undetected or was ignored by staff; excessive use of physical restraints by staff; excessive and prolonged placements in the Time Out rooms, which clients have described as being a concrete box which constantly smelt of urine; confinement in a small box under the dormitory at Mt Wellington; and excessive use of cruel and meaningless punishments and activities to manage behaviour.

99. In 2005, ERO made a series of negative findings about Waimokoia, including about the strong emphasis on behaviour management and control at the school, and the continued use of the Time Out room and other forms of seclusion. A September 2008 ERO report about the Residential Behaviour Schools highlighted ongoing governance and staffing issues at Waimokoia. Concerns remained about the use of Time Out and the approaches taken to behaviour management. The residential environment provided at Waimokoia was considered

"institutionalised". Copies of these reports will be provided to the Commission.[18]

100. On the basis of the 2008 ERO report and a report of an appointed Commissioner, Waimokoia was closed by MOE on 27 January 2010.

101. Between about 2008 and 2010, three former Waimokoia staff members were acquitted of several charges of physical abuse against children at Waimokoia in about 2007. Name suppression orders for all three staff members remain in force.

102. In 2009, a former staff member was brought to trial in relation to multiple charges of sexual abuse against several children at Waimokoia, between 1984 and 1988. The trial was aborted due to the staff member's ill-health. The staff member died in August 2009, before a retrial could be heard.

103. In 2010, former Waimokoia staff member Graeme McCardle was convicted of multiple charges of sexual and physical abuse of children at Waimokoia in the 1980s.

FAITH-BASED INSTITUTIONS

104. One of the most horrific examples of abuse in faith-based institution occurred at Marylands School in Christchurch. It was opened in 1955 and run by the Roman Catholic Order the Brothers Hospitallers of St John of God. It was taken over by MOE in 1984 and renamed Hogben School.

105. The religious staff at Marylands have been involved in around 120 allegations of sexual abuse dating back to the 1970s.

106. A raft of convictions followed. Brother Bernard McGrath was convicted of 21 charges in 2012. He also faced charges in New South Wales and was later extradited to Australia to face those charges. Brother Roger Maloney was found guilty of 7 charges in 2008 after being extradited from Australia. Brother Raymond Grachow was given a stay of proceedings relating to 8 charges of sexual abuse because he was too ill to stand trial.

107. Brother Bernard McGrath spent years after his time at Marylands working with the street kids of Christchurch in conjunction with an organisation known as Hebron Trust. In this context, he abused a large number of vulnerable boys and some of his convictions relate to this time period.

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[18] [Cooper Legal's Bundle, Vol. 2, tabs 10 and 11].

108. For many survivors, their experiences in Catholic institutions are characterised by severe physical abuse meted out by priests and nuns, and ongoing sexual abuse by both nuns and priests. Many experienced cruel and psychologically abusive events, such as being tied to their beds, having their hair shaved off, being deprived of food and being treated as slave labour.

109. Many expectant mothers, particularly unwed mothers in their teens, had their babies in Catholic or Anglican institutions. They were subject to cruel treatment, and some were forced to give up their children. We know that survivors of these organisations will speak to you directly.

110. When children were brave enough to disclose abuse, they were often shamed or punished, or told they were going to hell.

111. An example of this, which is also an example of the blurred lines of responsibility between the State and Church, is the example of the visiting priest at Hokio, a State institution for boys in Levin. He had free access to the Catholic boys at Hokio and could also take them away overnight. Several clients have described ongoing sexual abuse from him.

112. One boy disclosed the abuse to his local priest. The second priest told him that the best thing to do was to confess and make his peace with the Church, and that he was damned and not fit to be a Catholic. The priest made similar comments to the boy's family shortly afterwards.

HOW THE CLAIMS CAME TO LIGHT

113. After working as a lawyer in big firms for many years, Sonja Cooper started up her own practice in March 1995. At that stage, claims made by adults about abuse in care were rare. It was also thought there were insurmountable legal barriers to bringing a claim, although this was being challenged in the United Kingdom.

114. In August 1995, Sonja was appointed as a District Inspector of Mental Health. Through that work, she came in contact with adults who had been in psychiatric hospitals since their teenage years. Those adults talked about their terrible experiences in psychiatric hospital care. Many of those adults also talked about coming into psychiatric hospital care as State Wards. Other clients came to Cooper Legal from various sources, who had suffered abuse as children from their adopted parents, in foster care, in Church care and later on, in State-run residences.

115. In that period, through to the end of the 1990s, the State, through Crown Law, was unwilling to engage with the claims. This was due to legal hurdles, particularly the Limitation Act 1950. This meant that the early years were spent in the High Court, and subsequently the Court

of Appeal, working through whether adults who had suffered abuse as children in care (or were generally disabled) could still bring legal claims.

The Lake Alice Inquiry

116. The Child and Adolescent Unit of Lake Alice Hospital operated within the main hospital between approximately 1970 and 1978. For the majority of that time, it was run by Dr Selwyn Leeks. Lake Alice was a standard psychiatric hospital, with a Maximum Security Unit for the criminally insane.

117. The abuse which occurred in the Adolescent Unit is now a matter of public record. That includes the use of unmodified ECT as punishment, physical and sexual abuse, solitary confinement and placement in the wing with dangerous adult patients.

118. In December 1976, as a result of a complaint by a boy called Hake Halo, the first accounts of abuse at Lake Alice were received by ACORD and published in the Herald.

119. Hake's experiences and the Lake Alice inquiries will be covered by Oliver Sutherland, who we understand will give evidence about his involvement with ACORD.

120. Nearly a quarter of a century after Hake Halo's complaint, the then Minister of Health, Helen Clark, apologised to a large group of people who had suffered abuse in the Adolescent Unit. Over $10 million was allocated for compensation. Justice Rodney Gallen was appointed to determine how those funds should be allocated.[19]

121. The Gallen report, while not a formal Inquiry, set out for the wider public some of the experiences at Lake Alice. Justice Gallen had read the statements of every claimant involved in the case and interviewed 41 of the complainants. He found them credible and noted that there was independent corroboration of material contained in their statements.

122. Justice Gallen wrote:

> The children varied in age from the age of 8 years to the age of 16. The average age would have been in the vicinity of 13 or 14. Some children were admitted on a number of occasions, some remained at Lake Alice Hospital for extensive periods, others were there only for a comparatively short time. While some children had been diagnosed as having some form of mental illness, the vast majority were not so diagnosed. They were in fact presenting behaviour problems which for one reason or another were not controllable by

[19] Gallen report [Cooper Legal's Bundle, Vol. 2, tab 14].

> the persons who had responsibility for them, nor had those behavioural problems been controlled, in some cases, by placement in other institutions.
>
> Some were referred, on medical advice, by their parents, the majority were placed in Lake Alice by State agencies. Some had been subjected to severe physical and sexual abuse before their admission, others had suffered some kind of trauma which affected their ability to integrate into the community of which they were a part.
>
> All were in need of understanding, love and compassionate care. That is not what they received at Lake Alice.

123. Justice Gallen wrote that the basic theory at Lake Alice was that behavioural modification could occur through the imposition of rigid discipline and punishment of unacceptable behaviour. He recorded that electro-convulsive therapy (ECT) was in constant use on the children. It was not used as a therapy, but as a treatment. In the normal course of things, a patient receiving ECT is anaesthetised and given a muscle relaxant, and the electric shock administered while the patient isn't conscious. This is called modified ECT.

124. Many, if not most, children at Lake Alice received unmodified ECT. This meant that they were conscious, and they were not given a muscle relaxant.

125. It is clear from accounts at Lake Alice that not only was ECT given in unmodified form as punishment, but it was used at times in a manner even more cruel. The electrodes, normally placed on the head, were placed on legs and genitals. Children saw other children receiving ECT because staff thought it would deter them from behaviour considered unacceptable. One example is ECT being administered to the legs of a child who had run away.[20] Justice Gallen also made findings about sexual abuse of children at Lake Alice, by staff or other patients. One claimant described being locked in a wooden cage with a seriously deranged adult and crouching in a corner unable to get away. Justice Gallen described all the children at Lake Alice in the Adolescent Unit living in a "state of terror" while they were there.

126. There was significant media interest in the findings of the Lake Alice inquiry and the compensation package put in place. However, the response to Lake Alice, while flawed, represents the high-water mark of compensation packages for historic abuse in New Zealand. It also created a significant disparity between claimants who had been in the Child and Adolescent Unit, compared to people who had been in other units at Lake Alice, or other psychiatric hospitals or State care. Many felt that their experiences were overlooked due to the focus on the Child and Adolescent Unit at Lake Alice.

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[20] Gallen report, page 8 [Cooper Legal's Bundle, Vol. 2, tab 14].

The Growth of the Psychiatric Claims

127. In 2002, prompted by the Lake Alice Hospital Inquiry, this firm began to act for the claimants referred to above, who were in other New Zealand psychiatric hospitals (many of whom were also adolescents, but were not covered by the Lake Alice inquiry).

128. In the same year, the Evening Post did a story about claims for abuse in other psychiatric hospitals in New Zealand, and the number of people coming forward started to grow. Media showed photos of draconian restraint masks used at Porirua Hospital, and photos of nurses demonstrating the use of ECT.[21]

129. We did not do this work alone. Our colleagues Roger Chapman and Lisa McKeown at Johnston Lawrence worked alongside us and we split the client group between us. We could not have done this work without them and we gratefully acknowledge their work and support, right up until Roger's retirement in 2011.

130. Survivors wanted a similar Inquiry/settlement process to Lake Alice but it didn't happen. In 2004, Cooper Legal and Johnston Lawrence started filing claims. There were about 200 individual accounts of abuse at that time.

131. The Crown applied to 'strike out' the claims in 2005, using the Limitation Act and the immunities in the Mental Health legislation from the time.

132. The relevant Mental Health legislation contained immunity provisions, which protected persons acting in pursuance or intended pursuance of that legislation, from civil claims in respect of those acts, unless they had acted in bad faith and/or negligently. In such a case where bad faith and/or negligence could be established, a claimant could apply to the Court for leave to proceed, within six months of the alleged act taking place. The historic nature of the claims meant that this was not open to these claimants.

133. The Crown unswervingly and unapologetically took the view that all allegations made by the claimants, apart from those allegations of "major" sexual assault, whatever that may be, came within the immunity as "treatment", and that all claimants should have applied for leave to bring their claims.

134. The Crown asked the Court to approach the issues by imagining some way that all staff conduct, however seemingly outside the contemplation of the mental health legislation, could be in pursuance or intended pursuance of the mental health legislation. This included

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[21] [Cooper Legal's Bundle, Vol. 2, tab 23].

serious physical assaults, acts done as punishment (including burning someone with cigarettes) and minor sexual assaults.[22]

135. While this was happening, in 2005, the Confidential Forum was established. It allowed survivors of the psychiatric hospitals to tell their stories, but it had no power to respond or compel the Crown to take any steps[23].

136. Many people had a positive experience with the Confidential Forum. However, we also received a lot of feedback that the Confidential Forum provided no closure or formal response to their concerns. Reports to the Government were in the form of letters from the Chairman summarising their experiences. The Confidential Forum's powers were limited to assisting people to get their records, and some referrals to counselling. The transcripts of interviews and the experiences of participants were never made public in any meaningful way.

137. In the midst of the Crown's strike-out application, two psychiatric hospital claims went to trial. The first claim, *K v Crown Health Financing Agency*[24], was able to go to trial as it related to allegations of serious sexual abuse which therefore fell into the Crown's category of limited claims that did not require leave to proceed. This claimant, who suffered from an intellectual disability, did not manage to establish, on the balance of probabilities, that the events took place as alleged by him. Despite the claimant's intellectual disability, the claim was also barred by the Limitation Act 1950.

138. The second claimant, Mrs J, was able to go to trial because she had already obtained leave to proceed. Mrs J was a committed patient at Porirua Hospital from 1954 – 1960. She alleged physical, sexual and psychological abuse by staff and other patients. The claim, which became known as *J v CHFA*[25], had a number of successful factual findings, but also lost on the Crown's limitation defence.

139. The Crown's strike-out application ultimately went all the way to the Supreme Court. It was a costly exercise for all parties, and completely funded by the public purse. However, the Crown was only partly successful: the effective result has been that claims by informal patients arising from events which occurred after 1 April 1972 do not need leave at all, while in respect of most other claims the courts

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[22] *Crown Health Financing Agency v P and Ors* [2009] 2 NZLR 149 at para [46] and [53] [Cooper Legal's Bundle, Vol. 1, tab 4].

[23] Terms of Reference, Confidential Forum.

[24] *K v Crown Health Financing Agency* HC Wellington CIV-2005-485-2678, 16 November 2007, Gendall J [Cooper Legal's Bundle, Vol. 1, tab 6].

[25] *J v Crown Health Financing Agency* HC Wellington CIV 2000-485-876, 8 February 2008, Gendall J [Cooper Legal's Bundle, Vol. 1, tab 5].

would have to examine each one individually to decide whether it came within the class of cases which require leave.[26]

140. This result forced the Crown to start thinking about settlement for the first time.

Claims against MSD: The early days

141. As the claims about abuse in psychiatric care grew, it became clear that many people who went into the mental health system as adults, had a background of trauma as a result of being in State and/or faith-based care as children. It also became clear that many had been placed in mental health institutions by Social Welfare. While the claims in relation to the Lake Alice Adolescent Unit had been dealt with, many people who had been compensated for their time in Lake Alice had also been in Social Welfare institutions and/or other psychiatric hospitals for which no remedy or even settlement process had been offered.

142. There were also a lot of blurred lines about responsibility for some things. An example of this, is the large number of people who say they were taken from Holdsworth or Hokio on "day trips" to the Lake Alice Adolescent Unit for ECT as either treatment or punishment. Many talk about only waking up in the van on the way home, having wet themselves, with their entire body aching.

143. As the discussion about potential legal remedies for these harms became more widely known, the number of claims about abuse in Social Welfare care began to grow.

144. The first New Zealand claims establishing vicarious liability of the State for historic sexual abuse were *S v Attorney-General*[27] and *W v Attorney-General*[28]*.*

145. In *S v Attorney-General,* the High Court found the abuse had taken place as alleged and that the Department of Social Welfare was vicariously liable for the torts committed by Mr S's foster parents. It was found that Mr S was not barred by the provisions of the Limitation Act but was unable to be awarded compensatory damages because of ACC legislation.

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26 *B & Ors v Crown Health Financing Agency* [2009] NZSC 97 [Cooper Legal's Bundle, Vol. 1, tab 3].

27 *S v Attorney-General* (2002) 22 FRNZ 39; [2002] NZFLR 295 (HC) and *S v Attorney-General* [2003] 3 NZLR 450 [Cooper Legal's Bundle, Vol. 1, tabs 5 and 6].

28 *W v Attorney-General* HC Wellington CP 42-97, 3 October 2002, and on appeal *W v Attorney-General* (Unreported, Court of Appeal, CA 227/02, 15 July 2003) [Cooper Legal's Bundle, Vol. 2, tabs 7 and 8].

146. On appeal, the High Court's findings were upheld, however the Court of Appeal overturned the decision with regards the ACC bar – which meant Mr S was entitled to compensatory damages.

147. In *W v Attorney-General,* the High Court held that: the social worker who placed Ms W in the foster placement was negligent in that there was a failure to act with due skill and care in Ms W's placement; there was a failure to maintain relationships with family members; and a failure to act on complaints of sexual abuse. The High Court found that the Department of Social Welfare was vicariously liable for the social worker's conduct.

148. The Court also found that Mrs W was able to overcome the limitation defence. Once again, the Court also found that Ms W's claim was, in its entirety, barred by the ACC legislation.

149. On appeal the High Court's finding on the ACC bar was overturned and the Court found that Ms W was entitled to compensatory damages. The Court of Appeal also concluded, for the same reasoning as applied by the Court of Appeal in *S v Attorney-General,* that the Department of Social Welfare was vicariously liable for the abuse by Ms W's foster parents.

150. Both claimants in *S* and *W* negotiated substantial compensation amounts and payment of their legal costs.

151. Following these cases, through media reports, and word of mouth, from 2003 – 2007, the DSW claimant group grew exponentially.

152. As this happened, the climate in the Courts grew harder. With a snowball effect, the judiciary could not, or did not want to, deal with the implications of the claims.

153. In 2004-2005, the Crown indicated that it was willing to engage in an out-of-court settlement process. We began work towards that, but it never came to anything. By 2005, we were being forced to file formal proceedings in the High Court to preserve our clients' positions under the Limitation Act.

154. In 2006, Cooper Legal prepared a 175-page paper for MSD and Crown Law about the claims. It was a detailed breakdown of the claimants' allegations as they stood at that point. It identified staff members who had multiple allegations against them for either physical or sexual abuse (or both). MSD later passed this paper to the New Zealand Police, without the consent of our clients. It was the beginning of a long conversation, often challenging, about MSD's belief that it was entitled to breach our clients' privacy to provide information to the police, whether or not the police intended to act on it.

155. In 2006, Cooper Legal began filing formal proceedings against MSD in the High Court to protect the position of clients in respect of the Limitation Act. The number of claims filed in the High Court grew rapidly, much to the consternation of the judiciary.

156. Because of the large number of claims, litigation could not be managed in a normal way. It was agreed between Cooper Legal and MSD, and ordered by a Judge, that most of the claims would sit in court while we tried to settle them. If any identified claims needed to be progressed towards a trial, they would be pulled out of the group and dealt with in the normal way. Over the years, this has become known as the DSW Litigation Group Protocol. This Protocol is still in place today, although it has become more complex with an array of sub-groups, including a particular group for young clients, and claims relating to Campbell Park (with mixed responsibility by MSD and MOE) and claims solely against MOE. However, the Protocol still retains its primary purpose, which is to allow proceedings to sit in court to stop time under the Limitation Act, while we try to achieve an out-of-court settlement.

The White trial

157. In mid-2007, the first major trial about Social Welfare institutions in the 1970s was held. The two plaintiffs were known as Paul and Earl White.[29] The trial was effectively in two parts. The first part was about the care the plaintiffs had received while they lived at home, but under the supervision of Social Welfare. The second part was the care they received while they were in institutions. They had both been in Epuni, and Earl White had been in Hokio.

158. Building on the Court's findings in *S v Attorney-General,* Justice Miller Court stated that a duty of care arose between Social Welfare and a child who was at home but under status. This is an important part of State care that is often overlooked. The Court then made findings about the appropriateness of the way that the social workers had acted, including a time when the plaintiffs were placed back with their father, who was abusive towards them.

159. A large part of the decision related to the allegations about Epuni and Hokio. In relation to the institutions, the Court made findings such as:

    a) Epuni had been shut down in September 1972 for several weeks, shortly before Paul White was admitted. This was the culmination of longstanding problems.[30] Epuni was overcrowded, and boys were absconding *en masse*. Staff

[29] Name suppression orders remain in place. The citation for the decision is *White v Attorney-General* HC Wellington CIV-1999-485-85, 28 November 2007 [Cooper Legal's Bundle, Vol. 2, tab 11].

[30] *White v Attorney-General* at [157]-[158].

members who were writing to the Director-General said that children who were not delinquent on admission were educated in crime by others. Epuni was short-staffed and the staff who were there were inexperienced. Mr Howe, the manager, failed to delegate and was resistant to change. He admitted all new boys through the Secure Unit and should not have done so. Some changes were introduced and Epuni was eventually reopened;[31]

b) The Court specifically said that it was a feature of the trial that many of the witnesses (11 in relation to Epuni and 14 in relation to Hokio) did not know one another at all or had not seen one another for years. The Court stated that they gave evidence because they found their way to Cooper Legal or read publicity about the claims. Justice Miller said there was no real suggestion that they concocted their accounts, which were very similar in certain respects, or that they were suggestable. This specifically responded to a constant Crown position that witnesses were all talking to each other, making up stories, or regularising their accounts in order to gain more compensation. This is still the position of MSD today;

c) In relation to Epuni, the Court held that most boys admitted there were held in Secure for 23 hours a day, apart from showering and a period of PT. Almost all had received a blanketing (initiation) on arrival and all described a hierarchy of boys headed by a Kingpin. Several described staff members openly using the Kingpins to keep order.[32] It was noted that a former housemaster, Mr Moncrief-Wright, had been convicted of sexual offences against children in 1972. Another staff member, Mr Tjeerd, was dismissed in the face of allegations that he handled the boys roughly. In the end, the Court accepted most of the evidence of former residents at Epuni. He described them as impressive witnesses, their subsequent criminal histories notwithstanding. The Court accepted that Paul White had received an initiation beating at Epuni and that staff were aware of Kingpins and turned a blind eye to the enforcement of their authority.[33] The Court found that housemasters must have been aware of initiation beatings. He made findings that housemasters Mr Weinberg and Mr Chandler were violent towards the plaintiffs and that they were violent towards other boys as well;

d) In terms of Hokio, the Judge found that Earl White had been sexually abused by Michael Ansell who he described as notorious among the boys. The Judge found that a number of former staff members, including Mr Michael Gardner and Mr

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[31] *White v Attorney-General* at [160] [Cooper Legal's Bundle, Vol. 2, tab 11].
[32] *White v Attorney-General* at [189]-[192].
[33] *White v Attorney-General* at [225].

> Davidson, were unreliable witnesses. As with Epuni, the Judge found that Kingpins were a feature of Hokio. He also found that Pākehā boys had a harder time of it at Hokio, because they were outnumbered. Justice Miller found that Hoko Gardiner and Mr Davidson encouraged violence by Kingpins and Mr Davidson had watched violence among other boys without interfering. He found that Mr Davidson and Hoko Gardiner had both been physically abusive.

160. Despite these findings, the Court found that the plaintiffs' claims were barred by the Limitation Act 1950. They were given no remedy by the High Court.

161. Were the claimants in *White* substantially different from Mr S and Ms W? Not at all. The real difference was, that by the time *White* came to trial, it was in the context of, literally, hundreds of cases which were potentially going to proceed down the litigation path.

162. Unfortunately for the later claimants, the Courts were well aware of the other claimants "waiting in the wings" – which had not been the case in 2002/2003, when the claims were just starting out. The result therefore, was that the evidence now required to establish even a "prima facie" case that a given claimant could overcome a limitation defence, was substantial.

163. From this time, the Limitation Act became the primary weapon of the Crown. In a series of interlocutory hearings on Limitation, claims were lost on technical grounds.

164. Without any funding, Cooper Legal appealed the *White* decision to the Court of Appeal and sought leave from the Supreme Court, in both cases unsuccessfully.

THE LEGAL BARRIERS

165. Another complication in these cases is the effect of our Accident Compensation legislation – something that is unique to New Zealand. During the course of this work, the accident compensation legislation has posed a number of hurdles. This is not only because the Acts have been repealed and/or amended along the way (on one occasion in direct response to an historic abuse case we had successfully argued), but they have also proved difficult to manoeuvre through and have prevented some claimants from successfully claiming either ACC or damages.

166. Where the law now stands is that claims for general or compensatory damages for physical abuse can only be brought if the abuse occurred before 1 April 1974. In the case of sexual abuse such claims can, generally, only be brought if the abuse occurred before 1 April 1974

and the claimant has not had treatment for that abuse. Claims relating to psychological abuse may or may not be caught by the ACC legislation – depending on when the abuse occurred, and the nature of the damage suffered.

167. The ACC legislation does not prevent the ability for historic abuse claimants to seek exemplary damages, in other words, damages that punish the wrongdoer. In the New Zealand context the law in this area has also been developing as the cases have been argued.

168. In the case of exemplary damages, the Supreme Court has been clear that the amounts to be awarded are not to be excessive. The highest award we are aware of, to date, is $85,000. Typical awards are around the $20,000 - $45,000 mark.

169. From the time the *White* decision was issued, through until 2012, the civil claims faced a range of legal and practical barriers, almost always put in place by the Crown. These included:

a) The effect of the Accident Compensation legislation;

b) The withdrawal of Legal Aid; and

c) The Crown's approach to the Limitation Act defence.

The ACC Barrier

170. It is for Parliament to consider whether the bar on compensatory damages imposed by the ACC legislation is appropriate for the kind of systemic abuse which the survivors experienced. We would say that ACC does not provide an adequate response to any victim of physical or sexual abuse, particularly where that person has been the victim of systemic and sustained abuse throughout their childhood in care.

The Role of Legal Aid

171. By the time the *White* and the two psychiatric hospital decisions were issued, and the appeal of *White* was underway, there were hundreds of claims waiting in the wings. Virtually all claimants were in receipt of Legal Aid. These losses cast a shadow over the other claims.

172. In January 2008 Legal Aid decided to reconsider the availability of legal aid. Legal Aid issued a directive that we were to 'stop work' on our clients' files – except for urgent or court-timetabled work.

173. In April 2008, Legal Aid commenced a formal process of the withdrawal of legal aid for the claimant group (then numbering over

800), by requiring that Cooper Legal and Johnston Lawrence provide submissions in relation to each client's file.

174. This task was undertaken. If Legal Aid made a decision to withdraw legal aid, both the relevant client and Cooper Legal were advised of the decision in writing. Those decisions were reviewed and appealed to the Legal Aid Review Panel ('LARP')[34]. Each Panel was required to have at least one lawyer on it. That resulted in further appeals to the High Court (brought by Legal Aid and subsequently the clients). In the meantime, Cooper Legal was expected to do the bare minimum of work on individual files.

175. This was a very difficult time. Not surprisingly, our clients were very distressed at the thought that their funding might be removed. We had to reassure clients that we were continuing to do all that we could to protect each client's legal aid (and therefore their ability to continue their claim), but also reduce work to the minimum – given that we had little to no funding, and certainly no funding to progress substantive work.

176. There were also financial consequences. Cooper Legal could not guarantee ongoing employment to our staff. Half the legal staff left over the next several months, which meant the firm was not forced to make staff redundant. One of the office assistant positions also had to go. From approximately mid-2008 – late-2011 the firm coped with considerable financial uncertainty.

177. Particularly during mid-2008 – mid-2010 the firm did a considerable amount of work (nearly one million dollars' worth), unfunded, to protect our clients' positions while we "battled" through the withdrawal of aid process.

178. During this time, we progressed the *White* claims to the Court of Appeal and Supreme Court on a pro bono (unpaid) basis. We estimate well over $200,000 dollars was spent trying to get justice for the White brothers. Most of that money has not been recovered.

179. Matters were made more difficult during this period because Crown Law, in the full knowledge that legal aid had been withdrawn from a growing number of plaintiffs, and that for those who still had funding there were massive delays at Legal Aid's end with granting funding, insisted that cases be set down for hearings, including interlocutory hearings to deal with Limitation Act issues (effectively strike-out applications) and also trials.

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[34] The Legal Services Act 2011 changed this body to the Legal Aid Tribunal, or LAT.

180. On at least two occasions, the Crown pushed for a limitation hearing on particular files, and legal aid was withdrawn before the hearing[35]. The first time that happened, the case was adjourned because the Court accepted that we would have been ready to proceed when the case was first set down for a fixture, but that had not gone ahead because the defendants did not file evidence in time.[36] Legal Aid had been withdrawn after that earlier fixture had been delayed. The second time, the High Court refused to adjourn the hearing and also refused to let the firm withdraw as counsel. While the firm could have done a few limitation hearings for free, we had 800 clients in the wings. In addition, each client needed to have a psychiatrist (or psychologist) prepare expert reports. These cost a lot of money. It simply wasn't possible for Cooper Legal to foot the costs for everyone. In the second case, legal aid was reinstated days before the hearing. Even still, the client was at a massive disadvantage by then.

181. These examples show the huge inequality of arms our clients face every day.

182. It would have been, in many ways, an easier option for the firm to have "walked away" from the historic abuse work during the period 2008 – 2012. In deciding to fight for the client group, the firm had to make difficult, and what may have appeared to be unpalatable decisions from time to time – to protect the ongoing viability of our work for the hundreds of clients we represented.

183. It is important to acknowledge very strongly that our relationship with Legal Aid is a positive one now. We are grateful for the ongoing support of Legal Aid and we are constantly mindful of using public funds wisely. We are also pleased that, almost every time we settle a claim, Legal Aid receives a substantial contribution to the costs it has paid. Not many legal aid providers can do that.

The Crown Litigation Strategy: Defend at All Costs

184. Prior to 2012, Crown Law and MSD (the principal defendant) were supposed to act as Model Litigants. Model Litigants should, among other things, endeavour to: avoid, prevent and limit the scope of legal proceedings wherever possible; not contest liability if the real dispute is about quantum; not take advantage of a claimant who lacks the resources to litigate a legitimate claim; and not rely on technical defences unless the Crown's interests would be prejudiced by the failure to comply with a particular requirement.[37]

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[35] *Bron v Attorney-General & Anor* HC Wellington, CIV 2007-485-698, 17 July 2009.

[36] *LRB v Attorney-General & Anor* HC Wellington, CIV-2008-485-1541, 19 November 2009.

[37] Referred to in 'Litigating Against the Crown', April 2010, NZLS/CLE paper at pages 4 – 9.

185. Without any substantial public consultation, in 2012 the Cabinet Directions for the Conduct of Crown Legal Business removed the Model Litigant obligation, replacing it with an obligation to act in a manner which "satisfies the Crown's objectives". This altered the approach that Crown Law could take to the civil claims.

186. In our cases, as we have referred to, it meant that the Crown pursued, vigorously, the setting down of hearings in the knowledge that no funding was available and sought punitive orders in the event that timetabling orders were not complied with. Crown Law continued to raise the Limitation Act as a barrier to claims. This position was supported by the Courts.[38]

187. We note that a defendant always has a choice about whether they raise defences like the Limitation Act. It is not mandatory. We would like the Royal Commission to consider what guidelines or policies should be in place when the Crown is forced to defend its own actions in a legal or a dispute resolution context.

The Confidential Listening and Assistance Service ("CLAS")

188. In 2008, modelling on the Confidential Forum, the Government established CLAS. Judge Carolyn Henwood was appointed as the Chairperson. We understand Judge Henwood will speak to her experience of CLAS, so we do not intend to address it in-depth here.

189. CLAS ran for 7 years. Much like the Confidential Forum, it received the oral histories of care leavers and survivors. CLAS assisted with accessing counselling, with obtaining records, and referred people to the Historic Claims Team and our firm.

190. Unfortunately, the enormous amount of valuable information received by CLAS has been destroyed. CLAS has acted as a vacuum and then a black hole for the experiences of survivors.

191. Nevertheless, we acknowledge Judge Henwood's courage in taking CLAS beyond its terms of reference and rendering a great deal of assistance and comfort to care leavers during its lifetime. The final report of CLAS, issued in June 2015, was the first substantial, public reflection on the experiences of so many people. In her personal tribute at the beginning of her report, Judge Henwood wrote:

> 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.

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38 *LRB v Attorney-General & The Salvation Army* HC Wellington CIV-2008-485-1541, 11 March 2010 at [26]-[28].

> 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 that they were not watched over, nor protected. They were not valued, not heard, not believed and not safe.

192. At a time when the Government refused to acknowledge systemic abuse in the system – taking the approach often referred to as the "few bad apples" syndrome – this was a bold statement to make. It was also completely accurate.

193. Judge Henwood noted that CLAS had been set up as a kind of truth and reconciliation forum, modelled along the lines of post-apartheid hearings in South Africa. CLAS summarised the experiences of people who were in Social Welfare and psychiatric care and stated that the legacy of this situation required a whole of government response. Specifically, Judge Henwood stated: "Now that this Service is closing, there will need to be alternative routes for other people to resolve their concerns, rather than turning to the Courts."

194. Once again, we acknowledge the work of Judge Henwood and her colleagues. We encourage you to read the final report of CLAS, and not let the recommendations and experiences set out in that report go unacknowledged.

Changing the conversation: a human rights perspective

195. While CLAS was operating, the civil claims were still mired in the aggressive Crown Litigation Strategy and problems with Legal Aid, which continued through to 2012 or thereabouts. The continual barriers put in place by the Crown, in particular, meant that we needed to think differently about how we could get redress for our clients. We began to make noise on the international stage. Here, we acknowledge the advice and support of Dr Tony Ellis as we began to address why the Crown's actions were not just a breach of the duty of care it owed to survivors, but a breach of its international obligations.

196. The language of torts deals with negligence, assaults, battery and abuse. The language of human rights uses words like torture and cruel and unusual punishments or treatment. We have always been clear that many acts against children and vulnerable adults in care were acts of torture.

197. We have already talked about the use of unmodified ECT. Locking children in cupboards and dog-boxes was common. Violent exorcisms performed in faith-based institutions and foster placements were reported. Excessive, painful physical training, including carrying heavy objects while duck-walking while being assaulted was part of the Secure Unit regime at many institutions. In 1998-1999, young men were chained up and urinated on in a bush programme approved by

CYFS. Others were forced to stand naked all night while buckets of water were thrown over them. Others were chained to horses and dragged along riverbanks. These acts meet the definition of torture but have never been treated as such by the State.

198. New Zealand ratified the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) on 10 December 1989. Article 14 of UNCAT provides that New Zealand should ensure that a victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible.

199. New Zealand has entered a reservation to this provision, which says that compensation will be paid only at the discretion of the Attorney-General. In our view, this reservation needs to be removed so that the full force of UNCAT can operate within our domestic laws. The UN itself has said that the reservation should be removed.

200. UNCAT was made a part of our domestic legislation through the Crimes of Torture Act 1989. This is a little-used statute, with narrow definitions and with a requirement that the Attorney-General consent to any prosecution under the Crimes of Torture Act.

201. In short, it is the government's lawyer who decides what torture is, who should be prosecuted for it, and who should be compensated for it. The Attorney-General is also the defendant in all civil claims against the State.

202. We made our first submission to the Committee reviewing New Zealand's compliance with UNCAT in May 2009.[39] Cooper Legal complained that the New Zealand Government, which had an obligation to promptly and impartially investigate allegations of torture, had instead raised numerous barriers to investigating and compensating claims. We said that the Crown approach of requiring a lengthy, traumatic and adversarial process was a breach of UNCAT.

203. The next year, Cooper Legal started to include an allegation that the State had breached provisions of the Bill of Rights Act 1688 in our statements of claim, which is still in force in New Zealand. Those provisions prohibit cruel and unusual punishments. For people who were in care prior to the ratification of a number of United Nations Conventions in the late 1980s, this was the only provision we could "hang our hats" on. It was not accepted by the Courts.

204. Since our first submission to the Committee Against Torture, we have made a number of other submissions to United Nations bodies. In

[39] Cooper Legal Shadow Report UNCAT, May 2009 [Cooper Legal's Bundle, Vol. 2, tab 18].

February 2015, we made a further submission to the Committee Against Torture.[40] In that report, we said that we had 643 clients awaiting resolution of their historic claims. As at 25 January 2015, 307 of those were filed in the High Court. MSD had acknowledged that it had a backlog of 470 direct claims and 300 filed claims.

205. The Committee Against Torture noted our previous complaints and required the State to update it on information about redress and compensation measures. The Government relied on a lack of prosecutions under the Crimes of Torture Act 1989 to say that compensation should not be awarded. We complained that the definition of a victim of torture under the UNCAT was broader than the national legislation provided. We drew the Committee's attention to current issues, including that the State had said it would never accept a breach of section 9 of the Bill of Rights Act without a Court making a finding to that effect. We also complained about the way the Crown was acting in relation to a trial, and its refusal to consent to name suppression for witnesses who would give evidence of physical and sexual abuse in care.

206. In late October 2015, we complained to the Special Rapporteur on Torture about a proposed settlement process by MSD.[41]

207. In February 2016, we made a further shadow report to the Committee examining New Zealand's compliance with the International Covenant on Civil and Political Rights[42]. This addressed some wider issues we were working on at that time for prison inmates, but again complained that the State had failed to provide an effective remedy for harm it had done to people in its care.

208. In September 2016, we provided a shadow report to the United Nations Committee examining New Zealand's compliance with the Convention on the Right of the Child (UNCROC)[43]. New Zealand ratified this convention in 1993. As part of this work, Sonja Cooper went to Geneva as an observer during New Zealand's session, and spoke to Committee members about our concerns.

209. We provided a further shadow report on New Zealand's compliance with its international human rights obligations this year under the Universal Periodic Review process.[44]

210. The effect of these shadow reports has been to create an international spotlight on New Zealand's compliance with its international obligations in respect of abuse in care, and how it treats people who

[40] Cooper Legal Shadow Report UNCAT, February 2015 [Cooper Legal's Bundle, Vol. 2, tab 19].
[41] Letter to Special Rapporteur on Torture, October 2015 [Cooper Legal's Bundle, Vol. 2, tab 21].
[42] Cooper Legal Shadow Report ICCPR, February 2016 [Cooper Legal's Bundle, Vol. 2, tab 16].
[43] Cooper Legal Shadow Report UNCROC, August 2016 [Cooper Legal's Bundle, Vol. 2, tab 17].
[44] Cooper Legal Shadow Report UPR, July 2018 [Cooper Legal's Bundle, Vol. 2, tab 20].

seek redress. After each report, the relevant Committee has made adverse comments about New Zealand's compliance, which has put pressure on the State to respond in a different way.

The New Zealand Bill of Rights Act 1990

211. We have always said that people who were in State care after 25 September 1990 have additional claims for breaches of their rights under New Zealand's Bill of Rights Act 1990. Some of these rights include:

    a) The right not to be subjected to unreasonable search or seizure (where a number of programmes carried out strip-searching without lawful authority);

    b) The right to be free from arbitrary detention (where MSD staff members have, themselves, referred to the use of an island known as Alcatraz as punishment as a false imprisonment, and where the use of Time-Out rooms, seclusion rooms without lawful authority and other small areas can be considered arbitrary detention);

    c) The right, for a person who is detained, to be treated with humanity and with respect for the inherent dignity of the person; and

    d) The right, for a person who is detained, not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

212. There are many questions that remain unanswered in the legal context. For example, we say that a child who is in the custody of Social Welfare or CYFS, or someone who is in a psychiatric hospital under a Compulsory Treatment Order, is "detained" for the purposes of the Bill of Rights Act. We also say that the use of third-party programmes such as Whakapakari does not change MSD's obligations under the Bill of Rights Act or lessen its liability for breaches of the Act. There is still no case law about what compensation would be awarded for some of these breaches.

213. Currently, 3 plaintiffs are scheduled for a trial beginning in August 2020 to determine these very important legal issues and, what compensation should be paid.

The May 2011 Agreement – MSD

214. In May 2011, MSD and Cooper Legal signed an agreement to 'stop time' under the Limitation Act for claims settling out of Court.[45] Legal Aid was reinstated for this purpose. This was a watershed moment for the claims, and we began to work towards an ADR approach.

The constant battle for information

215. A constant theme for claimants seeking answers about their childhood, and redress for harm done to them, is that they were faced with an immediate barrier when it came to receiving a copy of information about themselves. Claimants are entitled to receive a copy of their original records under the Privacy Act. By 2013, but because of the multiple requests made by this firm, it could take over a year for MSD to process a request. The delay between requesting information and receiving it was becoming longer, and longer. The information was also heavily and improperly redacted or incomplete. This created immense problems for claimants who needed to understand their records, and Cooper Legal as lawyers trying to put a claimant's case together. Cooper Legal made multiple complaints to the Ombudsman about these delays, as well as the Privacy Commissioner.

216. In March 2015, Cooper Legal filed a group claim in the Human Rights Review Tribunal ("HRRT") on behalf of around 90 clients of Cooper Legal for whom records had been provided anywhere between 7 months and 18 months after a request had been made. Eventually, settlement was reached. Claimants received between $500 and $12,000 each, depending on whether a client had instructed us to accept the first offer, or made a counter-offer (which resulted in a substantially higher settlement), and the length of the delay in providing records.

217. These settlements, combined with ongoing complaints by Cooper Legal, resulted in a substantial improvement in the time MSD took to provide records to claimants. The issue of the heavy redactions continued. Redactions were often also inconsistent, with some documents redacting some names or events, and others leaving that material visible. For some years, MSD redacted all court documents, in the face of protests by this firm. MSD is now having to make those documents available to Cooper Legal, causing further delays.

218. There were also problems with formal discovery provided by MSD, which was also incomplete. If a claimant was working off a heavily redacted copy of information provided under the Privacy Act, it was not always easy to identify what was missing. MSD, using this position

[45] Limitation Act Agreement between Cooper Legal and MSD, May 2011 [Cooper Legal's Bundle, Vol. 2, tab 22].

of power, took a narrow view of what was relevant and removed material which was rightfully accessible by a claimant. Cooper Legal made applications about this to the High Court, which resulted in a High Court decision which ordered MSD to provide two versions of documents: one which was redacted and one which was "clean" or unredacted, with the second copy not to be shown to anyone except Cooper Legal without consultation with MSD first. This allowed Cooper Legal to progress a claim much more efficiently, with much better information.

219. It has also become clear over the years that the personal files of children in care did not include key information, such as when a child reported abuse by a staff member. This material was recorded separately, on staff files, and often no mention was made of it in relation to the individual child. Many of those staff files have now been lost or destroyed, including a large number as a result of a directive given by MSD management in October 1999.

Settlement Processes – MSD

220. There is not the scope within this brief of evidence to talk about the intricacies and changes to the various settlement and redress processes used by MSD over the years. It is fair to say that there have been many iterations of the settlement process and none of them have delivered a consistent, appropriate, or meaningful response to survivors.

221. In the early days of the settlement process, social workers from MSD's Care Claims Resolution Team ("CCRT") met with individual survivors. However, the backlog rapidly got out of control and the meetings were abandoned in favour of written claim documents provided by Cooper Legal. We understand the CCRT, which is now renamed the Historic Claims Team, continues to meet with self-represented claimants.

222. At all times, MSD has controlled the investigation, assessment and compensation processes. There has never been an independent voice or a system of checks and balances over these processes.

223. MSD has often changed the process, sometimes with little or no notice to Cooper Legal. We were forced to be reactive rather than proactive, changing our processes to accord with the Ministry's wishes. Many survivors got "stuck" in between changes of process, meaning that they experienced additional delays on top of the delays every survivor has experienced. Some work also had to be re-done to MSD's satisfaction.

224. MSD consistently looks to documentary evidence for sexual and serious physical assaults when the nature of these assaults means none typically exists – but will turn a blind eye to corroborating claims.

225. MSD is also inconsistent in what it accepts from survivors' claims over time. An example of this is how it treated claims about Mr Ngatai, a former staff member at an institution. He is now deceased. MSD did not accept allegations that Mr Ngatai was a sexual abuser for many years. It settled a number of claims for a lower amount of compensation on that basis. In recent times, MSD has changed its position and has accepted that Mr Ngatai was sexually abusive towards children in institutions. It has paid compensation to some claimants for abuse by him. It is not revisiting settlements made on the basis that it did not accept he was an abuser. This has created disparity between survivors who are the victims of the same abuser.

226. MSD has consistently said that it has obligations to its past and present staff members. This is clearly inconsistent with any attempt to independently and dispassionately investigate claims of abuse by those staff members.

227. By 2016, the backlog of claims sitting with MSD was significant. It was simply not possible for it to work through them in any timely or thorough way. MSD proposed an alternative, optional process called the Fast Track Process, which would apply to claims received by MSD prior to 31 December 2014. This was an alternative to the "full investigation", which was the standard process which took a very long time.

228. The Fast Track Process relied on an MSD staff member accepting a claimant's claims at face value and assessing compensation payable to the claimant against a set of categories. Payments under the Fast Track ranged from $5,000 to $50,000.

229. The Fast Track Process was deeply flawed. Firstly, insufficient funds were allocated for the number of claims MSD wished to address under the Fast Track Process. MSD was forced to "moderate" claims to fit the compensation payable into a bell curve. This immediately pushed most claims down one category, and sometimes two categories. It deflated almost every single claim to fit within budget.

230. The Fast Track Process also treated claims inconsistently. Where younger claimants had been on programmes like Whakapakari, or placed with other providers like Youthlink, MSD said it was not liable for abuse in those places and did not consider that part of a person's claim. The Fast Track Process did not take account of "practice failures", which we have talked about earlier, or breaches of the Bill of Rights Act 1990. These important things were not covered by a settlement which was going to be full and final.

231. These problems meant that clients who should have been entitled to additional compensation under the Bill of Rights Act for abuse

suffered at, say, Whakapakari, were offered $5,000 under the Fast Track Process. Claimants with similar experiences who settled under the full process have received $60,000 or more. However, the impoverished nature of our client group meant that many accepted these small settlements against our advice. Most came to regret it later. The full and final nature of these settlements means that the disadvantage cannot be undone, unless MSD agrees to revisit the settlements on the recommendation of the Royal Commission.

232. Many survivors talk about abuse by other children at different programmes and placements. MSD has the benefit of a statutory immunity in the Children and Young Persons Act 1974, and in the 1989 Act, which says it cannot be made liable for the acts of a child or young person in care.[46] MSD will pay compensation for some acts by children against other children in care, but only where a survivor can show that it occurred as a result on inadequate supervision by MSD's staff or agents, or that it occurred at the direction of a staff member. This is incredibly difficult for most survivors to show. Cooper Legal has the benefit of documents reflecting staffing levels and difficulties at institutions and placements over the years, which means that we have more tools available to us to demonstrate times on inadequate supervision in institutions. However, that is no guarantee that MSD will accept that position, and even in the face of documented evidence of poor supervision, MSD may not accept the allegation or pay compensation for the harm caused.

233. Recently, the only survivors who have really been compensated at an acceptable level are those whose claims have been pushed along a litigation path, and who were in care after 25 September 1989 (when the Bill of Rights Act was in force). This has come at enormous cost and time, which could be better spent on a more efficient process for the group as a whole.

234. Recently, MSD has engaged with Cooper Legal to try to make its processes more appropriate for Māori survivors, or Ngā Mōrehu. Cooper Legal engaged in good faith in these discussions, and facilitated conversations between some of our Māori clients and MSD. There has been no visible change to MSD's process which would be more meaningful to Māori.

235. However, MSD recently introduced a new process once again, and once again Cooper Legal is required to respond to it.

The most recent iteration

236. MSD's new process is based on an assessment that looks more like the Fast Track Process. It relies on an assessor, employed by MSD,

[46] Section 394, Oranga Tamariki Act 1989.

reviewing the allegations of a survivor against a set of categories and assigning compensation on that basis. How this will be done is unclear, because MSD has redacted all meaningful material from its documents about how the assessments will be done. This means that nobody can see the rules by which MSD is assessing claims. Cooper Legal has made yet another complaint to the Ombudsman about this, and an investigation is currently underway.

237. MSD has begun assessing claims by survivors under this new process, even though it has not told Cooper Legal or survivors representing themselves what the actual process entails. There are some 40-50 claims where assessments had been started under the old "full investigation" process, which remain unfinished. They appear to be stalled, while MSD moves on to new claims and a new process.

Settlement Processes – MOH

238. On 20 December 2011, the Minister of Health approved a settlement offer being made to all clients with psychiatric hospital claims existing as at July 2011. Offers were made to all clients in that group, whether their claims were filed in the High Court or not. It included offers being made to a reasonably significant number of clients whose claims had been discontinued for various reasons, particularly the withdrawal of legal aid process.

239. In 2012, Cooper Legal settled over 320 psychiatric hospital claims, under a process agreed to by the parties. The settlements were confidential, although the Crown has recently waived that confidentiality, if survivors wish to discuss that aspect of their settlements.

240. Settling these 320 claims was a significant achievement. We now only have a handful of psychiatric hospital cases left which were not caught by the settlement process. Those claims are, again, being dealt with out of court.

241. MOH's Historic Abuse Resolution Service is the agency which now deals with these claims. The Service was approved by the Minister of Health in 2012. Under the current process, MOH will consider any claim relating to abuse in a psychiatric hospital, as well as any claim relating to abuse in other state hospital contexts, provided the claim relates to events prior to 1993. All claims after that date must be directed to the relevant District Health Board.

242. After 2012, the top payment available to claimants has been halved – that is, the highest payment now available is $9,000, with the lowest being $2,000. The only way to improve on a $9,000 offer is for the claimant to produce a psychological or psychiatric report (at great expense) showing that they would be able to overcome the Limitation

Act defence, within a court context. In that scenario, MOH may increase the amount offered to $18,000, to bring it into line with offers made under the former process.

243. Unlike MSD and MOE, MOH generally does not rely on records to prove that abuse happened. This means that there is a high success rate for claims. Settlement offers are relatively consistent across claims of a similar nature and can be reviewed. If challenged, MOH will reconsider the claim and, crucially, will compare the claim against previous settlements, to ensure consistency. This has resulted in an improved offer for several clients of this firm.

244. The MOH process is also fast – typically, for represented claimants, the whole process is complete within two months. The process for unrepresented claimants, which involves meeting with MOH and allowing time for MOH to request relevant records, takes longer.

245. Finally, MOH will revisit a claim to consider additional allegations made by a claimant, even if a claimant has already made a claim and accepted a settlement payment. If warranted, MOH will then offer a top-up payment. A claimant will not receive an additional payment if they have already received the maximum payment, or if the additional allegations are not serious enough to warrant a payment above what was originally offered.

246. There are flaws to MOH's process. MOH will not consider claims made on behalf of deceased claimants. Further, there are transparency issues with MOH's process. In particular, there is little information available about MOH's process in the public space and no information at all on MOH's website.

247. Finally, as we have mentioned, the cap on the quantum available is a significant drawback and means that outcomes are often disappointing for survivors, who do not feel that the seriousness of their individual experiences have been adequately recognised. Unfortunately, after years of litigation, the current process, and its limitation on settlement amounts, it is all that is available to claimants of abuse in hospital care.

248. The MOH process illustrates the disparity between settlements for abuse in the Lake Alice Child and Adolescent Unit and settlements received for abuse in other psychiatric hospitals. One claimant, P, received $6,000 for abuse in one psychiatric hospital, and $81,500 for abuse he suffered in the Lake Alice Adolescent Unit. P was a child in both places. He experienced traumatic events and physical abuse in both places, and sexual abuse in Lake Alice. The gross disparity between the two settlements is difficult to explain to a survivor.

Settlement Process – MOE

249. MOE's process was set up to address claims for abuse at residential special schools before 1993. This timeframe excludes people who were at special residential schools after that date, or those who suffered abuse at State schools before 1989,[47] or at schools attached to Health Camps.

250. MOE's own website appears to limit this narrow scope further, stating that only those who suffered abuse at a residential special school run by the Department of Education before 1989 can make an historic claim. This is simply legally incorrect. While MOE has agreed to consider other claims, it will only do so an ad hoc basis.

251. MOE's process is plagued by extensive delays, which are growing worse. While MOE received claims from as early as 2010, the number of claims being directed to MOE has continued to increase. The claims, which initially related mostly to Campbell Park, now relate to a number of different schools. Many of these claims are modern ones, with complex factual and legal issues.

252. One of the main hurdles impeding the resolution of claims is the mixed responsibility of MOE and MSD for some claims. There is no fixed process between the Ministries about how to resolve them. Their processes, timeframes and compensation guidelines are different, giving rise to major inconsistencies and unfairness.

253. These ongoing delays further traumatise survivors within the MOE group, many of whom are highly vulnerable due to learning disabilities or poor literacy.

254. MOE claims remain exposed to the Limitation Act 1950. Unlike MSD, MOE has never agreed to enter a "stop time" agreement under the Limitation Act. We have no option but to file all claims against MOE in court, which uses time we could otherwise divert to resolving claims in the ADR process. Additionally, we are aware that MOE will not assess a claim on the basis of court pleadings alone, but will wait until it has received further settlement documents from us. This again causes delay and uses additional public funds.

255. MOE commonly rejects allegations if there is no documentary evidence to support the allegations. Further, it ignores propensity evidence and supporting documents from other cases, which would be considered within a court context. Combined, these factors set an impossible standard for an abuse victim to reach.

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[47] The Education Act 1989 shifted responsibility to Boards of Trustees after that date.

256. Settlement offers from MOE vary widely, though typically range from $5,000 to $35,000. Higher settlements are for people who were abused by staff members who have been convicted of sexual abuse at the same school.

257. There has also been a tendency by MOE to minimise the seriousness of allegations accepted by it as having occurred – for example, reframing physical assaults by staff members as inappropriate use of discipline. This inevitably reduces the amount offered by MOE to compensate survivors.

258. Finally, as we have said, claims for abuse after 1990 are subject to the Bill of Rights Act. These include serious claims of sexual abuse, physical abuse and confinement in Time Out rooms, which is a false imprisonment. To date, MOE has not accepted a breach of the Bill of Rights has occurred, even in the most horrific cases.

Settlement Processes – Churches

259. Faith-based institutions have an enormous range of responses to civil claims for abuse in care. This makes it very difficult to address all possibilities, and so our evidence on this point reflects some examples of our experiences, but by no means all the available processes.

260. We also acknowledge that different faith-based institutions will give their own evidence about their responses to civil claims.

261. The New Zealand Catholic Bishops introduced a protocol in 1993 called *A Path to Healing, Te Houhanga Rongo.* While this is a good process on paper, it is inconsistently applied. We note:

    a) Different orders of the Catholic Church can, and have, opt out of the Path to Healing process, and instead use their own processes. Sometimes, this is limited to instructing lawyers and declining to engage with survivors at all;

    b) Different sexual abuse protocol committees appointed by the Catholic Church utilise investigators, who have varied backgrounds and skill sets and sometimes are not appropriate individuals to be engaged in a pastoral process. Many investigators have a background in the Police, and both survivors and the investigators often have pre-existing views which make the investigation process a difficult one; and

    c) The approach to the *Path to Healing* process, and the time taken to investigate claims, varies greatly depending on which region of the country is dealing with it.

262. Claims brought against the Anglican Church, and its various parts, have not been the subject of any consistent or transparent process. In our experience, several parts of the Anglican Church rely on the Limitation Act as a total response to claims and decline to be drawn into any kind of pastoral process.

263. Earlier in our evidence, we talked about Marylands School, and the number of Brothers who had been convicted of sexual abuse of children there. The Order of St John of God has taken responsibility for the abuse at Marylands, and for abuse perpetrated by Brother Bernard McGrath in his later role with street kids and engages well with civil claims. The St John of God Order is Australian, and, in civil claims in Australia, has paid out vast amounts to survivors from Australian institutions. The ACC scheme has had such a dramatic effect on compensation in New Zealand that the St John of God Order pays considerably more compensation than any other organisation in New Zealand, but still views this as vastly less than it would pay, had the same abuse occurred in Australia.

264. The Salvation Army process is largely managed by an individual employed by the Salvation Army to do this work. At times, the process has worked well. At other times, the process has broken down and the lack of any checks or balances or external appeal provisions has hampered the progress of civil claims. We acknowledge that, currently, the Salvation Army is engaging very well and has acknowledged that, among its staff members and Church members, a culture of abuse existed, particularly in a number of institutions for children. Several Salvation Army staff members have also been convicted of the abuse of children.

265. There are a myriad of other faith-based organisations and institutions, all who have a varied response to civil claims. Incorporated societies which may not come within the Terms of Reference of the Royal Commission also have a role to play, as organisations which contracted with MSD or its predecessors for the care of children. Many of those organisations were faith-based. At all times, we have encouraged faith-based institutions to acknowledge their moral duty to children who were placed in their care, and to engage in a meaningful and pastoral process with survivors. As you can see, this has been met with a mixed response.

The impact of the Welfare system on Māori

266. We have always been aware that Māori have been disproportionately affected by the systems and practices of Child Welfare and its successor agencies since its earliest inception. There will be other people better placed than us to speak about this. However, we are clear on the following things:

a) That over the lifetime of the claims, our clients have been disproportionately Māori;

b) That we see in the individual claims, that Māori children were more likely to be uplifted from their homes, were more likely to be separated from their siblings, and were more likely to be charged with offences;

c) We saw that Māori tāne were more likely to be placed into institutions rather than foster homes or with whānau members; and

d) We see, on a distressingly regular basis, both unconscious and blatant racism in the records in experiences of our Māori client group.

267. We are also aware that the impact of Welfare intervention is inter-generational. Our clients are connected by whānau and hapū and iwi connections, but often do not find each other until they are adults, if at all. Many are isolated from the culture and from Te Ao Māori. An enormous number of our Māori male clients are in prison.

268. In May 2017, Sonja Cooper provided a brief of evidence to the Waitangi Tribunal for Wai 2615. This was an urgent Inquiry into the matter of Māori children placed in the care of the State. In that evidence, Sonja explained the settlement processes that were operating at that time by MSD and MOE. Sonja responded to affidavit evidence provided by the Crown. Sonja explained the lack of any Tikanga Māori understanding in the process, and that most of our clients never met anyone from MSD and, when they did, it was stressful for them. Sonja set out the real evidential problems with MSD's settlement process and the significant delays which were a part of it. Sonja set out our concerns about the settlement process, in particular that it was not independent of the Government. Sonja talked about the lack of any other advocates for care leavers, except for lawyers. The brief also talked about the difficulties in obtaining counselling sessions for our clients, even though MSD said in its evidence that support or assistance would be available. We also doubt whether the Ministry's statement that it would deal with all of the claims before 2020. That was clearly never going to happen.

269. Finally, Sonja's evidence dealt with the health and wellbeing of our Māori clients. We set out the basis of many of their claims and also addressed similar problems with the Ministry of Health and Ministry of Education claims.

WHERE WE ARE TODAY

270. As we have said, we represent about 1,250 people who are currently seeking redress from the State or faith-based institutions for harm done to them as children or vulnerable adults. Sadly, this number is not declining. Some months, Cooper Legal receives up to one new instruction or client a day. We interview each client face-to-face and work as quickly as we can to put their claim documents together and progress their claim with the relevant body.

271. However, we are continually hampered by delay and changes to processes. The immense delays by MSD, in particular, and MOE in responding to claims means that we spend a lot of time explaining why this is happening to survivors and following up with MSD and/or MOE about why nothing is being done. Sometimes, survivors are distressed, angry and bitter about how long the process is taking, or about how the relevant defendant responds. We cannot blame them for this. Many say they should never have started the claims, because dredging up their childhood experiences has done them more harm than good, particularly in the absence of any form of acknowledgement from the State or faith-based institution.

272. With such a large client group, we have extraordinary visibility over how whole families and whānau have been affected by decades of involvement with Social Welfare and its successors agencies, in particular. We can see several generations all taken into care as children, with the resulting loss of culture, loss of language, and disconnection from the whenua and their whānau. The role of social workers and Social Welfare over the years is often described as a tool of colonisation by many Māori, and we certainly agree with that description. It will take several more generations to undo this harm, and it is not clear yet that we have even begun.

273. We acknowledge that there is a discretion by the Commission to hear from people who were in care after 1999. We are very pleased about this, because we see so many young people who come to us, who are still experiencing abuse in care today. One thing so many of our clients say is that they do not want what happened to them, to happen to other people.

274. One of the challenges for younger claimants is that their allegations may relate to a person who is still employed by MSD or Oranga Tamariki, and who still has a role in caring for children today.

275. MSD has dealt with this issue poorly. At one point, it provided a large amount of information provided by claimants for the purposes of their claims, to the New Zealand Police or third-party care providers without the consent of any of those claimants. MSD says it has a duty to provide this information, and that it is protected by an exception in the

Privacy Act which allows for the provision of information to protect children from harm. While we have no concerns if the information is anonymised so as to protect the privacy of our clients, MSD maintains its position that the identity of a claimant must be provided as well. This means the information can be provided to the alleged abuser by a third-party organisation or by Oranga Tamariki. This creates safety concerns for many claimants, some of whom still have a very real fear of retaliation by caregivers, many of whom had gang affiliations and made threats against claimants when they were children. Having their identity provided to other parties is an unintended and very unwelcome consequence for many claimants.

276. Cooper Legal has taken steps to protect our clients from this breach of their privacy. The issue of whether, and how, MSD can pass information, not only to the New Zealand Police but to Oranga Tamariki and other organisations which may have employed these people, remains a live issue and is currently before the Court of Appeal.

CONCLUSION

277. We are lawyers using limited tools to try to bring about a truth and reconciliation process to break what we say is a cycle of harm in Aotearoa New Zealand.

278. The civil claims are only one part of this challenge. A reckoning with the truth, and a commitment both to healing the past and changing our future will take more than legal action. It will take structural, long-term change and commitment over many generations.

Dated: 5 September 2019

Sonja Cooper / Amanda Hill

Appendix A

Staff members of State or faith-based institutions convicted for physical or sexual assaults

- Anand, Edward: convicted in May 2016 in relation to 8 complainants at the former Girl's Home in Elliot Street, Dunedin, between 1980 and 1986.

- Ansell, Michael: indecent assault on boys in 1969 and 1976 (the latter charges relate to boys at Hokio).

- Calcinai, Vincent: a staff member at Epuni, convicted of six charges of sodomy and 8 charges of indecent assault in 1973 against 3 boys at a State school. Later charged with further offences and committed suicide in November 1996.

- Chambers, Ivan: convicted of multiple charges in 1984 and convicted on 8 counts of indecent assault on boys at Epuni in May 2011.

- Cooper, James Hemi Barlow: convicted of eight charges of physical abuse on boys at the Heretaunga Maori Executive in November 2013.

- Gainsford, John: Sentenced to 10 years imprisonment for sexual abuse of children at the Salvation Army Temuka Home.

- Fuimaono, Ioana (Joanna): caregiver at the Fa'afouina Trust, pleaded guilty to assault with intent to injure.

- Hampton, Bede: Convicted of sexual abuse of boys at a Catholic boarding school.

- Hookway, Ross: convicted in September 2006 of 12 charges of sexual offending against a child in his care. Mr Hookway was a Salvation Army caregiver.

- Jobin, Graeme: convicted of sexual abuse of boys in 2012. Mr Joblin was known by CYFS to work with street kids and children were left in his care.

- Leef, Kaperiere Petera: convicted of sexual abuse while teaching at Hato Petera College.

- Maloney, Roger (Brother): conviction on 7 charges of sexual abuse in 2008 after being extradited from Australia.

- Mathers, Terrence: convicted of multiple sexual assault charges in May 1984.

- Matthews, Bully: in February 2004 or thereabouts, Mr Bully was convicted for assaulting boys in his care at the Heretaunga Maori Executive.

- McCardle, Graeme: staff member at Waimokoia School, convicted in August 2010 of 15 charges of indecent assault and sexual violation.

- McDonald, James Duncan was convicted of 11 sex offences in 1978 (2x) and then again in 1988 (9x). The offences were committed on boys and girls over the years 1968 to 1982. The charges dated back to the period Mr McDonald was at Holdsworth.

- McGrath, Bernard (Brother): convicted of 21 charges in 2012. He also faced charges in New South Wales and was later extradited to Australia to face those charges.

- McKay, Bryan: Convicted of indecent assault on boys at a Marist Intermediate in Hamilton.

- Moncrief-Wright, Alan: convicted of multiple charges of sexual assault in 1972 and 1986. Mr Moncrief-Wright worked at Epuni and Hamilton Boys' Home.

- Purcell, Peter: convicted and sentenced for physical assaults on boys in his care in August 2013. He was a caregiver for the Heretaunga Māori Executive.

- Robinson, Noel: staff member at Campbell Park convicted of multiple sexual assaults on children prior to 1986.

- Shepherd, Elvis Dobson: convicted for sexual assaults while teaching at Hato Petera, later employed at Hato Paora.

- Tukapua, Maahi: convictions between 1972 and 1979 for indecent assaults on boys. Mr Tukapua worked in Hokio.

- Vince, Raymond: convicted of sexual abuse of multiple young girls in the early 1980s at the Salvation Army Temuka Home.

- Walmsley, Frank: convicted of 52 sexual assault charges in total. Frank Walmsley ran the Oamaru Family Home for a 5-year period in the 1990s.

- Watson, George: staff member at Wesleydale arrested for sodomy on a former resident in his off-duty hours. It transpired that Mr Watson also had a previous conviction for sodomy which he did not disclose on his application form and the Principal could not remember whether he was questioned about this when employed at Wesleydale.

- Wilson, Rex: jailed for 12 years for abusing children while a CYFS-approved caregiver.

- Woodcock, Alan: convicted of sexual abuse at St Patrick's, Silverstream.

Appendix B

Programmes provided pursuant to s396 of the Oranga Tamariki Act 1989:

Whakapakari Programme ("Whakapakari")

1. In July 1989, a Whakapakari resident was seriously assaulted by other residents and a supervisor. Whakapakari staff told other boys the assault was so serious that staff said the boy had died. Documents show the boy was beaten and burned with cigarettes over a two-hour period.

2. In 1990, CYPS issued a caution about Whakapakari and the appropriateness of placing children there.

3. In 1991, CYPS was told that conditions at Whakapakari were inappropriate and had resulted in residents trying to abscond.

4. In 1994, CYPS was told that residents were refusing to return to Whakapakari because they felt intimidated and had been assaulted by staff.

5. In 1995, CYPS staff recommended no further placements at Whakapakari until significant changes were made.

6. In 1995, a female resident became pregnant to a supervisor, who was convicted of unlawful sexual connection.

7. In August 1995, CYPS received complaints about: low staff wages; rotten food; rat-infested tents; lack of first aid equipment; refusal of medical treatment; residents trying to kill each other; a supervisor punching a resident in the face; and a boy being severely beaten by four other boys. CYPS staff again recommended no further placements at Whakapakari until changes were made.

8. In August 1997, a Whakapakari resident told CYPS staff he had been seriously assaulted by a Whakapakari staff member, which resulted in the resident struggling to breathe.

9. In 1998, an investigation was held after a group of boys alleged they had been sent to work for a member of the Headhunters as punishment. The man discharged firearms over their heads, set dogs on them and forced them to dig holes "big enough to be buried in".

10. In 1999, the Office of the Children's Commissioner undertook its own review about the complaints in paragraph [9], above. This was critical of CYFS's investigation into the incident.

11. In 2002, a Whakapakari resident told CYFS he had been assaulted by a Whakapakari staff member, resulting in a broken collar bone.

12. In 2003, CYFS again investigated Whakapakari after a resident alleged he was assaulted by a supervisor, who threw him against a doorframe.

13. On 15 March 2004, all 18 residents at the Whakapakari Programme were removed, after multiple allegations of physical abuse and neglect. CYFS described a "culture of violence" at Whakapakari.

Moerangi Treks

14. On 28 June 1995, CYPS received a complaint from a former resident at Moerangi Treks, who alleged he had been subjected to serious violence by staff and other residents.

15. On 18 September 1997, a resident complained he had been repeatedly punched and hit by supervisors, including the Programme Leader. He also alleged he had been attacked by a large groups of residents, on the instruction of supervisors.

16. On 28 November 1997, a local iwi organisation complained to CYPS about Moerangi Treks, stating that: the camp ground was dilapidated; there was very little hot water; and residents lived in cramped living conditions.

17. On 17 December 1997, CYPS received two further complaints. The first was regarding a boy who had broken his arm falling from a horse and had subsequently been admitted to hospital with pneumonia, which CYPS was not notified about. The second related to a game called "crash", during which residents were beaten on the instruction of staff members.

18. In May 1998, Moerangi Treks was investigated by CYPS. A report noted the following allegations:

    a) A resident said he had been hit on the head by a tutor, and then kicked for reporting the assault;

    b) A resident witnessed another resident being hit on the head by a staff member, using the butt of a gun;

c) A resident witnessed a staff member punch another resident twice, as punishment for not saddling a horse properly;

d) A resident was hit in the head with a closed fist by staff member NW, as punishment for throwing rocks;

e) A resident reported being bashed by staff regularly;

f) A resident reported being hit using a stick that looked like a broom handle;

g) A resident reported seeing other boys with bruises and burns, and said one resident stayed in bed for two days, after a beating;

h) Residents' phone calls were listened to by staff to prevent them reporting the abuse;

i) One resident report that: he was punched twice in the face by staff, which was a blanket punishment for another resident tying a horse up incorrectly; he saw a resident get choked by staff using a horse rope; he saw staff hit a resident using bolt-cutters; and he saw staff hit residents using the butt of a gun;

j) Multiple residents reported regular and severe beating by staff; and

k) A resident reported being hit using a piece of wood.

19. Later in May 1998, a CYPS report acknowledged that serious questions had arisen over some time about the care of residents placed at Moerangi Treks, and that all of the young people interviewed had genuine fears of reprisal for reporting the abuse.

20. On 2 June 1998, the approval for Moerangi Treks was suspended by CYPS. Moerangi Trek's staff members subsequently denied any allegations of abuse.

21. Four months after Moerangi Trek's approval was suspended, NW started Eastland Youth Rescue Trust, which was granted approval to care for young people under s396 of the Oranga Tamariki Act 1989 on 12 October 1998.

Eastland Youth Rescue Trust ("Eastland")

22. In December 1998, staff at Weymouth contacted CYPS after a resident alleged mistreatment at Eastland.

23. On 5 January 1998, another resident complained about treatment by a supervisor at Eastland. No action was taken.

24. On 7 January 1999, CYPS notified Eastland that it intended to investigate a serious complaint of physical abuse against a resident. However, the programme continued.

25. In response to the complaint in paragraph [23] above, CYPS agreed to continue funding Eastland, if staff addressed the following policy and procedure issues: the intake and assessment process; safety, relating to provision of care; discipline procedures; and staff support and supervision.

26. In May 1999, a resident made serious allegations of physical abuse, sexual abuse (including rape), punitive and cruel punishments, and neglect at Eastland.

27. On 21 May 1999, CYPS agreed that Eastland's approval would be suspended, and the residents removed.

28. On 29 June 1999, a local resident wrote to CYPS, stating, among other things, that at Eastland: the residents were "indoctrinated" by staff to hate the public; rifles were left in vehicles used by staff; and residents drove the trucks, unsupervised.

29. In June 1999, CYPS staff reported the allegations made by between five and 10 Eastland residents. This included, among other things, allegations of: physical assaults; sexual assaults; being dragged by horses; a finger being cut by an axe; being chained or tied up; sleep deprivation; being forced to run through blackberry bushes; being spat on; being burnt by cigarettes; being cut with a knife, including on the throat; being urinated on; being run over by four-wheel motorbikes; and being threatened at gun-point.

30. On 20 October 1999, CYPS revoked Eastland's approval under s396 of the Act.

Heretaunga Maori Executive ("HME")

31. In March 2002, CYFS noted that HME employed a staff member, who HME management knew had been previously convicted of assault.

32. In May 2002, CYFS noted that there were no vetting procedures or police checks for staff or caregivers by HME.

33. On 24 March 2004, a CYFS review noted that many remedial actions from previous reviews had not been completed. HME continued to be used by CYFS.

34. In 2004, a HME caregiver was convicted for assaulting boys in his care.

35. Between February and April 2007, CYFS received several different allegations and complaints about HME:

    a) Police expressed concern about the level of supervision and containment in remand homes, after two YJ residents absconded;

    b) Another young person who ran away alleged he had been given alcohol and a tracker had tried to assault him;

    c) A member of the community complained about heavy drinking by HME caregivers; and

    d) A resident, who was inadequately supervised, absconded from HME and consumed alcohol.

36. HME was permitted to continue caring for young people by CYFS.

37. In November 2008, further complaints were received by CYFS:

    a) A teenage son of a caregiver provided cannabis to a resident;

    b) Residents had been subjected to verbal and physical abuse by caregivers;

    c) HME provided a limited range of activities with little specifically tailored to the needs of residents;

    d) Residents had been subjected to racial abuse;

    e) Residents had ready access to drugs and alcohol; and

    f) Residents had been left unsupervised.

38. Further concerns were noted, including: overcrowding; a lack of activities for residents; a lack of proper systems and processes; and the lack of a complaints process. However, the approval of HME continued.

39. In March 2009, CYFS noted concerns that HME continued to employ a staff member, who had criminal convictions.

40. Further concerns were raised in November 2009. This included that: CYFS did not know where some young people in HME care were; HME refused to conduct police vetting on caregivers; HME refused to allow CYFS access to financial records; a resident had alleged assault by a caregiver, which was considered substantiated; and HME had poor records, processes, recruitment and training. The approval of HME continued.

41. A CYFS report from September 2011, noted concerns about physical punishment of residents and the lack of police vetting because several caregivers had significant criminal histories, including for drink-driving, drug offences and theft.

42. A review report in March 2012 raised serious concerns. For example, the report noted there were a number of allegations of abuse against residents that had resulted in criminal charges. However, HME's approval continued.

43. In 2013, HME staff member Peter Purcell was convicted and sentenced for physical assaults on boys in his care. The Manager of HME continued to support the employee and said the boys were lying.

44. CYFS finally suspended the approval of HME in September 2013.

45. In November 2013, HME's approval under s396 was revoked.

46. Subsequently, another staff member was also convicted of assaulting boys in his care.