ROSSLYN NOONAN - AFFIRMED

EXAMINED BY MR MOUNT

MR MOUNT: Good afternoon, Chair. The next witness is Rosslyn Noonan.

CHAIR: Thank you. Ms Noonan, as you commence your evidence, in terms of the Inquiries Act 2013, may I
15.42 inquire of you as follows - (witness affirmed).

MR MOUNT:

Q. Good afternoon, Ms Noonan. Just with some formalities. In front of you, we have a copy of your statement of evidence which is 94 paragraphs long with some appendices. Can you just confirm for us that you have signed that today and confirm it's true and correct to the best of your knowledge?

A. I have and it is.

Q. Thank you. In a moment, I will invite you to make any
15.43 introductory comments that you wish but could I just confirm that you are currently the Director of the Human Rights Centre at the University of Auckland School of Law and you were previously Chief Human Rights Commissioner for a decade from 2001-2011?

A. That's correct.

Q. Obviously, your evidence, in light of that background, will have a particular human rights focus?

A. Yes.

Q. I understand you may have some introductory comments that
15.43 you would like to make?

A. Thank you. (Opening comments in Te Reo Maori). Commissioners, survivors, advocates, Commission staff, Royal Commission staff, tena koutou tena koutou tena koutou tena koutou katoa.

I wanted to start by acknowledging the courageous testimony you heard today from Beverley and Annasophia and those survivors who appeared earlier in this Contextual Hearing and those we are still to hear from.

Whether in State care or abused in faith-based institutions, it's clear from their stories and from the response of the State and of the faith-based institutions to date, that ~~a~~ massive constitutional, structural, cultural, legal and moral and behavioural changes are
15.44 required in the way we protect the rights of our children and young people and those children and adults with disabilities who are in care.

The focus of my submission, perhaps slightly different from some others, is the State's response to the claims of abuse in care since 1999.

So, like Judge Becroft, I urge the Royal Commission to interpret broadly section 10.1 of the Terms of Reference in relation to its ability to consider matters after 1999. And just very briefly, the reasons I do so,
15.45 and there's probably two or three of them, is one, that how the State has responded to claims of abuse since 1990 reflect very much the reason why this Commission is necessary. Because effectively, successive Governments and agencies of the State sought to suppress general public knowledge of the abuse and violations that have gone on over many decades and actually, in my observation, took a number of measures to try to prevent an independent Inquiry of this nature being established.

The problem is that those same agencies will be
15.46 providing advice to Ministers about how to respond to this Royal Commission and its recommendations and are already doing so. And so, the extent to which - if their behaviour post-1999, and I will be giving some of examples of that, is not called into account, and if they

are not required to acknowledge the extent of their responsibilities at the highest level for the persistence of the abuse over many decades, then I'm afraid, no matter what you recommend, won't make any difference.

And, I mean, this is the critical, you know, this is looking at where power lies and what needs to be done to ensure that those with power are required to change and do in fact change.

And that won't happen if you don't look post-1999 because they have assured us all too often that they've sorted everything. Bad things happened before 1999 but since, you know, we've got it right, we changed the law, the law looks pretty good and don't bother us. You know, just sort out the historic stuff. But, as we know and as we've heard from Judge Becroft, the fact is abuse does continue but more importantly, there's no recognition. I think most - well, the abuse should be stopped but it won't be stopped unless there's recognition of the systemic failures of those at the highest level of government and government agencies with respect to this issue.

Q. In paragraphs 9 and 10, you have given us more detail about your personal background. Are there any aspects that you would highlight for the Commission?

A. Well, just very briefly, when I was preparing this, I realised that in the early 80s or the first half of the 80s, as an industrial officer with the Public Service Association, I represented social workers and assistant social workers. These were people working in the very institutions that we've been hearing how extensive abuse was.

And later on, from 1988 until the mid 90s, I was the National Secretary of Te Riu Roa, again representing teachers, psychologists, education advisers and others,

who were working with these children, either in state schools or integrated schools which they attended from the residences or schools attached to the institutions themselves.

So, I am concerned that the Royal Commission actually hear from those people because I think we know now, and we know a lot more probably about the impact that an environment of bullying, violence and intimidation has on staff, as well as on children and
15.50 young people.I am not excusing staff in any situation where children violated if they could have prevented it. But, again, I think this is where issues relating to leadership, management. What we know is any institution, the tone, the behaviour, the environment, is set by the leadership, it's set by the senior management. And in the State, in the case of state institutions, that senior leadership was at the national level. In the government agencies education, Social Welfare or MSD, health, as well as the heads, the managers, of the institutions
15.51 themselves. So, again, if there's really going to be any change, and it's unlikely that institutions as a whole will vanish, even though ideally that might be desired, we need to understand what the mechanisms are that allow culture, a culture of violence and bullying and intimidation to persist. And that means focusing on the management and the leadership, not just the so-called bad apples which again has been the approach of the State to date~~day~~.

Q. I take it, you would advocate that we hear not only from
15.52 the people at those senior levels but also from those who were at the coalface?

A. Totally. I mean, I think you need to start with them because we need to hear what their experiences were, you know how they came to be caught up in some very, very

disturbing environments. And also, we do know that some of them tried to draw to the attention of Wellington what was happening, we know that now, and with no success. I mean, similar to the response to ACORD, the centre chose to ignore the evidence that was presented to them about what was going on and did nothing about it, other than try to suppress and hide it, they did do that.

And the other thing is, just again in preparing this, most recently I've Chaired the Te Korowai Ture
15.53 a-Whanau, which was the independent panel examining the 2014 family justice reports reforms. In that process we discovered a whole raft of systemic issues across the family justice services, that includes Family Court as a whole but all the related services around it, none of which had been adequately addressed. And those systemic issues are absolutely central to the considerations of this Royal Commission. And again, I mean, obviously you can have access to the Te Korowai Ture a-Whanau report but in relation to the system wide issues that need
15.54 addressing.

In addition to the failure to the cultural and the failure to take account of Te Reo Maori in any respect, they're also not responsive to Pasifika cultural needs or to those of our new migrants. But to me equally shocking was the fact that there was no systematic accommodation of people coming before the Family Courts with disabilities and many of the family justice services, including the Courts but not limited to the Courts, were not accessible basically. We discovered that hearing
15.54 loops weren't regularly serviced and fixed and there was no way, there was no provision for asking people beforehand formally what support they needed to effectively be able to participate in the Court's proceedings, although we were assured by Judges that of

course if they knew someone was disabled they'd go out of their way to help them. So, a totally inappropriate charity model which should have gone out with the - you know, disabled people shouldn't have to beg for something extra in order to get equal access to justice.

And I think that the fact that that was still the case with respect to the Courts, and I am sure it applies across all, not just to the Family Court, really reflects, in my view, the seriousness of the issues
15.55 relating to disabled people, disabled children and adults who require significant care or in State care or other institution care.

Q. If we move to part 1 of your statement, paragraph 20, perhaps to introduce the topic, we've heard over the last 8 days of this hearing of the numerous claims of abuse in State care over the years. I take it, during your time as Chief Human Rights Commissioner you became aware of those claims and formed a view about the government's response. Would you like to introduce your views?

15.56 A. Yes. I will try to summarise them. So, essentially what happened, was that after the Gallen J Lake Alice compensation process and the publicity that surrounded that, you know the media coverage, and I mean I think we've heard this from Sonja Cooper and Amanda Hill, what effectively happened was that a lot of people who had been in Lake Alice or in other psychiatric institutions in New Zealand and who had suffered appalling treatment in one form or another, came forward and said, you know, we need to be treated in the same way.

15.57 At the Human Rights Commission, the first case that came to us called Kelly's case. She was a young woman who was obviously very naive, very young, young 21 year old committed to Lake Alice for reasons I can't go into but she was actually placed in the Adolescent Unit. And

she came to us because she thought that it was unfair that just because she was not, you know she was over the age, even though she'd been in the Adolescent Unit and had been treated the same way as many of the young people, you know, there was evidence of the treatment of young people, including use of ECT and so on, that she couldn't be compensated for that because it had really damaged her life in many, many ways.

Anyway, I won't go through it. I'll summarise what
15.58 I see as the key characteristics that prove to be common to the State's response to virtually all these claims throughout.

First of all, the Ministry of Health and Crown Law simply, the mediator who was working with her said, swatted the complaint away, claiming they didn't even have to sit with her, come to the Commission, mediate, because the Lake Alice' process were only for children, who were children at the time. So, they wouldn't even enter into mediation or listen to her. They claimed of
15.59 course if she was 21, then she couldn't be in the Adolescent Unit.

Actually, when we were able to retrieve what records existed, for the most part they provided corroborative evidence that she had been in the Adolescent Unit. And there weren't many details of the ill-treatment she received but there was enough to suggest that it had gone on.

And we took those back to Crown Law as evidence that it should come to the party and mediate with her. The
15.59 Crown Law Office informally met with her but nothing came of it. Just to say, following that, I mean, she didn't have - she couldn't face going public over what had happened to her, which is why she didn't join any of the class actions that were being put together for other Lake

Alice patients, and she didn't feel she could go to the Human Rights Review Tribunal on the age discrimination claim that she'd come to us with for the same reason, that she'd have to publically disclose what had happened to her.

But what we did do with her instead, was help her put together her story in detail with her records and so on, which she took to the Confidential Listening and Assistance Service. And she did find that experience 16.00 affirming, not closure, you know, nobody would think there would be closure but certainly that was a positive experience.

But the key characteristics, as I said, the unwillingness to look at a non-adversarial approach to dealing with these claims. The difficulty in accessing her records, we did manage to get some. I did actually at one stage, myself, meet with the then Deputy Secretary of the Ministry of Health and, you know, I tell you, New Zealand's public sector records they've been subject 16.01 to more fires, more floods, you know, worms, other things that have affected them and caused surprising and usually very specific files to disappear. You know, we were given all sorts of reasons why her records were intact.

But fundamentally, and this is again what I found hugely problematic, was a complete lack of empathy for her situation, until she went to the Confidential Listening and Assistance Service. And it was as if the government officials, the Crown Law lawyers, Ministry of Health lawyers, as if somehow they had a stake in proving 16.02 her wrong, in dismissing her claim, as if there was, you know - I couldn't understand why, given this had happened a long time ago, they weren't personally responsible, I don't think there would be anybody left in the Ministry of Health who, you know, would have been responsible at

that time, and so why they needed to be so denigratory and dismissive of her and that attitude persisted.

Q. Just to refresh people's memories, we've heard that the abuses at Lake Alice were sufficiently acknowledged by the government, that I think a $10 million compensation fund was created. And the report of Gallen J condemned in the strongest terms what had happened there, so there was no secret about the existence of the abuses?

A. No.

16.03 Q. I take it, that's the background to your concern about the response to Kelly?

A. Yeah because, clearly, even on the basis of the limited records that we were able to access for her, it was clear she was there at the time when the abuses took place, that she was almost certainly for a period in the Adolescent Unit, given the staff that she could identify who were in that unit etc.

Q. Your hope might have been that she could push on an open door, rather than having the door slammed in her face?

16.04 A. Yes, exactly. In the expectation that there would be - you know, I think it was definitely in the State's interests to, you know, recognise that these abuses had gone on and to find a way to face up to them and provide some redress. And certainly, in human rights terms that's what was required. New Zealand had signed up to the Convention Against Torture, there was clearly inhumane and degrading treatment etc. but it was like, no, we're going to deny them or we're going to minimise them or we're going to try and suppress them.

16.05 Q. Did she ultimately have any compensation?

A. Unfortunately, we haven't been able to track down the final outcome because my recollection, and I've sworn to tell the truth so I might be wrong, but my recollection is that eventually, you know, because there was a kind of

health, you know, the Crown Health Financing Authority did do a kind of class settlement and she did receive something in that process.

Q. Further down the track?

A. Much further down the track but that may not be the case. And the mediator who worked with her was very unsure when I tried to - I haven't have a chance to really - the records now, the Human Rights Commission records will be well stored somewhere and it would take a huge effort to - so, she may have got something and I want to acknowledge that.

But anyway, yes.

Q. Shall we move to access to records which is from paragraph 32 of your statement?

A. As I say, one of the things that's consistently consistent in terms of the State's response to all of these cases, is either very poor or lost records. And certainly when care leavers have sought to access their records, they've had a hugely difficult time of it. And often, you know, I am aware of care leavers who receive - the first time they ask for their records they received records that were redacted virtually every page, like you know 100 pages and hardly a single non-redacted sentence.

Given that the records, all of the mechanisms that the successful Governments put in place to respond, put in place in the 2000s to respond to claims of abuse, all required, all required the claimants to be able to produce records that proved that they were there at~~dd~~ a particular time. But also, not only that, but that specific things happened to them. And if it wasn't referenced in the records, the tendency, and again you know I'll leave it to Sonja Cooper and Amanda Hill to provide you with a lot of that detail, but the outcome was, well, we don't accept your claim because there's

nothing in the records. So, you know, that affected the compensation levels.

One of the things that we did as part of - as we were advocating for an independent Inquiry, and this was prior to the change of government, so the National Government, the Human Rights Centre supported by the New Zealand Archives Professional Association organised a round table about the records and that involved people from National Archives but also from a number of the
16.08 faith-based institutions in terms of what records they had kept, as well as the Department of Internal Affairs etc.

What I've provided for in the submission is the sort of detailed summary of what came out of that day. I will perhaps highlight some points from it.

Basically, care leavers generally found that the only personal records that existed of their childhood are held by government departments who often choose to redact much or most of the personal information about the people
16.09 that they were surrounded by in childhood and those redactions were often also inconsistent.

If I can just tell you, one of the people who participated, a care leaver, and I hope she might come before the Royal Commission at some point, at the time of the symposium she was 79, so she had been put in foster care as a young child and because her mother was deemed to be developmentally or learning disabled to an extent, and it turned out that she had been put - it was later accepted that she had been fostered into a family where
16.10 the mother turned out to be seriously sort of psychotic, so she said before I die, I would just like to know everything that happened to me. And endlessly, request after request, complaints to the Ombudsman. At that stage, 2017, she had still not received a fully

unredacted copy of her records. Now, what possible harm could a 79 year old woman do to anyone who's mentioned in those records? Most of them would no longer be alive, at any rate.

And I am putting some emphasis on this area because I think it's something that probably the Commission needs to deal with sooner rather than later, is the fundamental question of who owns those records.

And if you think about it, virtually every other
16.11 record made about us here in New Zealand, our health records, school records, credit records, they're ours under the privacy legislation, we can ask for them, we can get them completely. But here, children who were in State care cannot get their records.

And then when they do get them, and I think we've heard this from one of the survivors, they only put negative stuff in.

And then very recently I've heard that people have had experience where there has luckily been maybe some
16.11 school photos or whatever, that the photos are being redacted on some spurious privacy grounds. Now, we know if you take - so, only the child's, the care leaver's face has been left. I mean, what sort of thinking is doing this? The care leavers themselves, following their symposium, they have never done this before but they were supported to make a submission to the Oranga Tamariki legislation on what should go into that legislation in terms of the records.But just to summarise what they themselves said in that submission, they provided details
16.12 of accounts of insensitive, disrespectful interactions at the point of hand-over.So, that's stuff that was happening in the 2000s and beyond.

Insulting, judgmental opinions.

Redactions which are neither consistent or fair.

Inaccurate, incomplete information and omissions.

They go on, and I think again I would urge you to look at what they recommended about what they see should be available to care leavers in terms of records from now on. And I think that what they propose is very practical, reflects a human rights approach, in a sense. That those who are most affected should be able to have a say about what should happen. So, here they've done that.

16.13 And it really gives voice to the children in care about the sort of records that would be appropriate for them.

So, as I say, I would like to ask that this be looked at early on, so that people no longer seeking their records no longer have to go through the sort of hoops.

And it may well come down to the issue of who owns these records. And, again, I mean, at the time we did have a look at the legislation and it's difficult to see

16.14 on what legal basis the agencies concerned claim that they own the records, as opposed to these being personal, you know, records which ultimately the ownership should be of the person about whom they are.

And obviously, there always has to be an exception, if there was a real threat of violence if someone found out the name of somebody who they felt had mistreated them, maybe that, but generally that's pretty rare.

Q. Just for the record, the full submission from Kelly's association is Appendix 2 to your statement, so the

16.15 Commissioners will be able to look at that in their own time.

A. I don't think the Oranga Tamariki legislation sufficiently took account of their submission, so that's an area that definitely needs change.

Q. Shall we move now to the Crown's litigation strategy from para 39?

A. Yes. Obviously amongst, you know, if we - if you think about the Crown's response to claims of abuse, I mean, the Crown summarised their approach as, and paragraph 22 of my submission I quote them directly, "At a systemic level, allegations of ill-treatment in a given institution".

Q. Just pause there for a second. I am mindful of those who
16.16 are having to interpret this for others, just do it slowly.

A. Okay. Paragraph 21, I quote the government's response to, the government's own summary of how it responded and it said, "At a systemic level, allegations of ill-treatment in a given institution are thoroughly investigated."

Well, I think we've heard enough to know I am not sure when that thorough investigation started.

And then, "For individuals who raise allegations,
16.16 Court and Police procedures have been supplemented with the Confidential Listening and Assistance Service which can provide support and other assistance and with an alternative resolution process which can provide compensation, apologies and other remedies".

And the very self satisfied summary, "The result is an integrated and comprehensive approach to addressing such allegations".

If you didn't know anything about it and you looked at the list of what they provided, so the confidential
16.17 psychiatric forum, Confidential Listening and Assistance Service, the Ministry of Social Development's care, claims and resolution process, the Crown Health Financing Agency, civil litigation, judicial settlement conferences, direct negotiations and criminal procedures;

it sounds like, you know, they had it covered. And that's what they sought to present internationally as well as nationally. But each one of those, while they had some positive elements had very, very significant flaws. And I guess we start with the Crown's litigation strategy.

Q. The first thing you've talked about at 39 is the Atkinson case?

A. Yes.

16.18 Q. Which is a reasonably well-known case but perhaps you can highlight for those who are not so familiar with it?

A. Yeah. So, this was a group of parents of severely disabled adult children whose adult children had been assessed as eligible for payment for care because they needed very substantial levels of care, personal care, and whom the State, and the State would pay anyone to provide that care except family members, direct family members.

In the case of I think the nine plaintiffs, all of
16.19 them had tried alternatives, in some case tried out-of-home care, in other cases had tried home based, but like stranger home based carers, all of whom had had serious problems, not least of which was because the adult children were so severely disabled people didn't stay for very long. If they were lucky to get someone who was - if they were lucky to get someone, and then they were lucky to get someone who was sufficiently skilled, it is such a demanding responsibility there was constant churn.

16.19 At any rate, the thing was these families came on the basis that it was family status discrimination which is unlawful in the Bill of Rights Act and Human Rights Act.

Once again, in the Human Rights Commission we try

always to find solutions because we accepted that, you know, complex environment, the Crown had very real resource constraints and other considerations, but the human rights approach says, you know, look at all of those with human rights involved and how can you provide with them, provide for them, without derogating from the human rights but obviously taking into account the real life complex issues?

And in this case, the Human Rights Commission had
16.20 developed, in co-operation with the Office of Disability Issues, so the government agency responsible, an approach which formed the basis of a Cabinet Paper which provided that family members could be paid providing they underwent same checks non-family members underwent and they were prepared to sign the same contract.

So, this was no question of, you know, risk to the government's finances at all. Everything was kept within a controlled framework.

Just before - I mean, it was on the Cabinet agenda
16.21 and went onto the Cabinet agenda. It was pulled by the Minister of Health and the Ministry of Health.

And so, rather than even come back and say, well, we need some further discussion. They took an extremely hard adversarial line that resulted in the family's concerned having to go through the Human Rights Review Tribunal, the High Court. So, one of the Human Rights Review Tribunal, very, very detailed decision. The Crown appealed. They won at the High Court. The Crown appealed, they won at the Court of Appeal.

16.22 In this process, two things. After the High Court decision, we'd been approached by the media, well I'd been approached by the media to give the Commission's response as at the Minister of Health at the time, this was Tony Ryall, it was the National Government. The

Minister rang me to say that he really wanted to warn me that these parents were rip off artists, they were just trying to scam taxpayers and that I should be very, very wary of them because, you know, evidence was going to come out about how they'd been defrauding the system and so on.

I was able to tell them that actually I knew, personally knew them, I knew that was complete rubbish, I knew where it was coming from and that if he went public
16.23 with that, he would be the one who didn't look good. That these parents were salt of the earth and while they may have made the odd mistake, it had only ever been desperately trying to do the best for their disabled adult children.

The Minister chose not to go on television but to issue a statement saying that he respected the parents. But that was typical.

Now, these cases went well over 10 years it took to come to an end. But the other thing the State did, and
16.24 again you've heard this in respect to abuse in care cases, the State used all its powers to, I don't even know what the right word is, but to really review every aspect of these parents' lives. And they found in one case that one of the parents had used money that she was given for respite care I think to put a fence around their little property because the disabled adult desperately wanted to have a dog and they couldn't have one without a fence. So, she did use money for respite care for the fence.

16.25 When MSD and health discovered that, they charged her with fraud which was an outrageous thing to do. It was part of them really seeking to intimidate the people who had the gall to bring a case against the State. Without going into all the details, anyway she went

before the Wellington District Court. She chose a jury trial and the jury found her not guilty in about 30 minutes. The thing about that because I will come on to say some harsh things about the courts but the thing about that is, it's almost certain if that had been a Judge alone case, he would have found her guilty because theoretically, not theoretically, you know, strictly speaking, she was guilty, she did spend the money for something other than what it was given to her but the
16.26 jury could see beyond that to what was justice.

And we came to see this very hard ball attitude. In the other case -

Q. Just before you do, have you summarised at 46 the key elements in your view of the Crown's response?

A. Yes. Rejected the option of a negotiated settlement in favour of litigation. Used every resource available to date to zealously defend their complaints. Attack the character of the complainants rather than taking a principled approach to litigating solely on the issues.
16.26 And ultimately, this is probably almost the worst, when they finally lost at the five bench Court of Appeal, under budget secrecy and urgency they introduced legislation which overturned the Court's decision, largely overturned it, and removed human rights protections for people in that situation, so there could never be another similar claim.

So, you know, if this had been any other country where a government had acted like that, we would have regarded it as an outrageous breach of human rights.
16.27 This was New Zealand.

I mean, the current government has a commitment to amend the legislation, restore the human rights entitlements, but it hasn't happened yet, as far as I'm aware.

Q. Shall we move then to the White case which is something that Keith Wiffin talked about and Sonja Cooper and Amanda Hill?

So, we have some information about the White case but would you like to summarise your perspective?

A. Yeah. So, I won't go into the detail because you know what it was about.

I mean, it was actually when I read this, that I realised that the decision in this case, that I realised
16.28 the Human Rights Commission had a responsibility to get involved in this area because effectively, two young boys, who had certainly been severely, you know, assaulted etc., abused by their parents, and were taken into care but then were further abused at Epuni and Hokio Boys, the decision of the Court acknowledges that. It acknowledges the bullying, it acknowledges the assaults by staff, it acknowledges the derogatory language used by staff and it acknowledges that one of them at Hokio was sexually assaulted by the cook. So, there's no question
16.29 that that actually happened.

But what shocked me was the decision in this case. The High Court found that basically because damage had been done by the family as well as by the State institutions, that there was basically no way that you could work out which was which. And so, taking into account the statute~~tory~~ of limitations, which the Crown invoked, and the ACC legislation, there was no compensation. But I think even worse, if you read the decision, I mean there's various points in it and again I
16.30 urge every member of the Royal Commission, it's like 100 pages or something but you should read it, because it illustrates the extent to which the Judge himself kind of treated them like criminals. And certainly if you read the transcript, the Crown's counsel treated them as if

they were the criminals, not the victims, and subjected them to the same sort of cross-examination, the same denigration, that they do of alleged criminal offenders.

At one point, for example, I mean if you read the decision it looks as if the Judge even is kind of blaming the boys for the fact that they were assaulted and bullied and things because of the way they behaved and their behaviour was difficult etc., etc.

In the transcript, at one stage the Crown counsel, 16.31 who to her shame was a woman, was suggesting that the boy who was molested did so because he liked to get cigarettes, so there was mutual benefit. He was 12 or 13. The Judge intervened at that stage and said, where are you going with this? You're not really suggesting consent, are you? And she said, oh no, no, it will soon emerge. But he didn't stop her. You know, I mean, this case, you know, a psychiatrist was called by the Crown to give evidence that because there wasn't a lot of publicity about sexual abuse in the 1970s, if you were a 16.32 child sexually abused in the 1970s it wasn't as damaging because there hadn't been media coverage, you know, it was the publicity that caused people to think they were damaged.

You know, and a number of other things but I think it showed conclusively that while the Court, and I'm not questioning, you know, the finer legal decisions of the Judge but in terms of justice for these men who had been severely damaged, there was none.

And I also, you know, the other thing that struck me 16.32 is I realised, of course, and again I think this is a fact you have to take into account in looking at why we allowed this abuse to continue for so long, is that those in positions of power were the Judges, Crown counsel, senior officials in government agencies, came and still

come from seriously privileged backgrounds for the most part. And the ability to even begin to intellectually kind of grasp what happened to these children and young people was clearly beyond them.

And all they saw was the outcome which, as we've been inclined to do, we then blamed on them. They got into drugs, you know, they committed crime, they ended up in prison, there was something fundamentally wrong with them, so you can't really, you know, be too concerned
16.34 about what happened to them previously because clearly there was something wrong with them that people treated them like that, and that is what has to change, you know, it really does.

But this was, you know, so in a sense both the Atkinson case - well, the Atkinson case, the Courts came to the party because actually, to be honest, the discrimination on the basis of family status, you know, it was so blatant that I don't think they could do anything else but they did and that was good.

16.34 But as far as the White case, it totally highlighted the attitude of the State to people who had the cheek to claim compensation for what had been done to them. And it was at that point that, you know, I recommended to the Human Rights Commission that we needed to monitor the State's response to see if it was meeting our ~~inter-national~~international human rights standards.

Having done that and made that public, I have to say that what I was then faced with was senior officials coming up to me and telling me, off the record of course,
16.35 that I should be very careful not to get too close to Sonja Cooper from Cooper law because she was basically just out to make money out of Legal Aid, by encouraging these people to take claims, which, you know, and really raising their expectations when she shouldn't be doing

that.

And I know from the staff member who worked on this, who worked on the Commission's review and monitoring of the State's response, that he got several of those warnings as well, probably with more graphic detail than I got because I basically shut them down quite quickly.

So, this was a whole - it was a strategy. About 2 years ago, before the Royal Commission was established and while we were advocating for its establishment and I
16.36 was quoted on the media at some point, I was contacted by a former senior official who said, he was ringing me to apologise to say that everything I'd said about their behaviour was absolutely correct and he was part of the interdepartmental group that was responsible for developing the strategy.

So, you know, that was the Crown's response and, to be honest, you know, my feaair is that apart from superficially, it hasn't necessarily changed and that the Royal Commission is going to have to be incredibly
16.37 careful and ~~skilful~~skillful in terms of what you take from the government agencies about this whole - because we can see how self-satisfied they were with~~about~~ what they provided.

And after this government announced the establishment of the Royal Commission, they produced a paper that showed that really it wasn't necessary because they'd fixed everything.

So, you know, I don't know if they've now changed their mind but -

16.37 Q. Just before we leave the White case, you didn't have this information at the time but of course I believe an Inquiry last year found both the Crown Law and MSD in breach of the Code of Conduct for their use of private investigators in the case with the potential use of surveillance against the White claimants?

A. Mm.
Q. I take it, that would be consistent with your statement at 50, that the Crown strategy was to use any means within or outside the legal toolbox to defend the claims?
A. Yeah, and that's obviously - I mean, they did that with the Atkinsons as well. The way they surveilled those families trying to find dirt on them, it was the same strategy.
Q. We will, of course, come back to the White case, I am a
16.38 sure, as part of the redress examination.
A. And I think what it raises is the whole issue of what was the litigation strategy and who was responsible for it? And I think somebody, oh I think Judge Becroft, you know, raised at the very beginning of his submissions the whole issue of privilege and what's protected by privilege, and I'm conscious that Crown Law has insisted that the litigation strategy is protected by privilege. Well, I think if the Crown is going to be open and fully transparent with this Royal Commission, it needs to
16.39 provide the litigation strategy that it used in the 2000s but which seem to have continued without much modification until recently and you need to get that.

Because I think it also gives rise to the question of, to what extent did the Attorney-General, who for most of this was, it would have been Michael Cullen, to what extent was he briefed and to what extent did he specifically sign off on this sort of behaviour? Because, I mean, you know, mostly I think that the senior officials, the Crown Law officials in the Ministry of
16.40 Health and MSD, should be held to account. But I think the politician, if there's a question about how much and at what point particularly the Attorney-General, Minister of Social Welfare, knew and approved of the particular approach, given how drastic it was.

Q. The next section of your statement addresses the non-legal mechanisms for responding, including the Confidential Forum for Former Psychiatric Patients and the Confidential Listening and Assistance Service.

We have heard about those to some extent already. Is there anything you'd like to highlight?

A. So, I'll just highlight two things. One is, I think they were setup, in the first case the Psychiatric Forum was definitely set up to try to stave off claims compensation
16.41 following Lake Alice when so many accounts of abuse in psychiatric care came forward. And I think if you look at the Terms of Reference and the extent to which nothing would be made public, even if people were prepared to have it made - you know, obviously you want to provide really genuine confidentiality but actually, these Terms of Reference really were intended to suppress any general knowledge of widespread ill-treatment in the Psychiatric Services and then subsequently even tighter, more restrictive Terms of Reference applied to the
16.41 Confidential Listening and Assistance Service.

You know, people will tell you that not necessarily, you know, I don't necessarily think we need lawyers or the time for everything but I think it was shocking that provisions, the Terms of Reference for both these services prevented people who came before them from having a lawyer with them if that's what they chose. Lawyers were banned. And I mean, again, you have to ask why? You know, the positive, you know, the seller, the PR version would be because we wanted it to be all
16.42 pally-pally and not legalistic or whatever but actually in reality, it was again I think much more to try to prevent anything that might be useful in claims against the Crown emerging in that process. So, that's what I would say. I would say, look, I admire the job that was

done by both, and particularly by the Confidential Listening and Assistance Service who went to huge lengths to get people's records, to provide support, you know, to get them decent support etc. So, the people, Judge Henwood and the team that she worked with, I mean they did a remarkable job but that was in spite of not because of the process. And, again, the intention of the State was clearly to keep all of this out of the public eye, again which is why this Royal Commission is so important
16.43 because, you know, I've had care leavers say to me, survivors say to me, the thing is, nobody knows what went on, you know, people in my family don't know, or friends or people in my workplace and if I was to tell them, they would think I was lying or that couldn't possibly be true.

And so, you know, for lots of survivors just knowing that the wider community understands that a whole lot of abuse went on and, you know, people were damaged by it, you know, so they don't have to say this is exactly what
16.44 happened to me but just like I was there at that time, you know, and even today I've heard of a case where only because of this Royal Commission, you know, a family has discovered that their family, one of their family members was abused in an educational institution in that instance.

This is why it's so important.

Q. Would you like to move on to monitoring mechanisms, paragraph 64?

A. Yes. Again, Judge Becroft has spoken about the
16.45 monitoring mechanisms. They were used as an excuse to make 1992 the cutoff date for the Confidential Listening service, the forum and the Confidential Listening service. And yet, not one of those monitoring mechanisms is or has been appropriately resourced really at any

time.

So, there's been a history of establishing monitoring mechanism. And I have to say, I do want to acknowledge in its very early days the Human Rights Commission, this is the early 80s, was the only State agency or State institution to respond to the ACORD evidence, and did undertake their own review and published a report about it which I have to say the Judge in the White case thought wasn't worthwhile his even
16.46 looking at, he preferred to have a report from the government agency concerned.

Yeah. So, and I think Judge Becroft, I mean, I think the issue around why the existing monitoring mechanisms weren't more effective, and obviously for the most part they were really only established late 80s/90s but I'd have to say I'm not sure that they've been hugely effective or as effective as they should be. Since then, in fact, there's some evidence that they haven't.

But I think it's more than just saying so we need to
16.47 establish another one on a slightly different basis. I mean, I think the Royal Commission, and those of us who have been involved in monitoring mechanisms, need to give quite a lot of thought to what's worked and what hasn't. What do we need to do to really create critical mass? In a small country like New Zealand, a whole lot of separate, you know, siloed institutions, I think have a great deal of difficulty delivering. And while I was Chief Human Rights Commissioner, and again this is on the record and raised at the time with the Children's
16.47 Commissioner of the day, I did express concern about the extent to which MSD restricted and provided, put pressure on the Office of the Children's Commissioner. And I thought most appropriately, it should become parts of the Human Rights Commission, still have a completely, you

know, the Children's Commissioner, you know, properly staffed, it wasn't properly staffed at the time but, you know, at least staffed as it was at the time within the Commission and that would - because the liaison department, the Ministry for the Human Rights Commission was the Ministry of Justice, whereas the Children's Commissioner had the mandate to investigate Child, Youth and Family etc. but MSD was their liaison department. So, that relationship was really problematic. Secondly, 16.48 National Human Rights Institution, of which the New Zealand Human Rights Commission is an accredited human rights intuition, they have to meet international standards of independence and those are reviewed every 4 or 5 years internationally. And so, there is more scrutiny of the extent of the independence than there can be with the Office of the Children's Commissioner. So, I think there's lots of things to explore. I often say to people who say Parliament is the answer, actually Parliament is always controlled by the government of the 16.49 day. Occasionally, Parliament steps, shows that it can do more but mostly in New Zealand the outcomes from Parliament is what the government of the day was.

But I think Judge Becroft has raised a very important issue and, as I say, it is something that the Royal Commission does need to consider.

Q. Shall we move on to the draft report prepared towards the end of your time as Chief Commissioner? This is from about 68 of your statement.

A. Yes. I'm kind of conscious of the time. I provided the 16.50 full draft report as an appendix because it is the one actually contemporary account that had gone through various iterative drafts with all of the agencies involved.

So, the information there is factually correct at

that time. I do want to say and acknowledge the work of the Commission staff, that through the process, and we had good engagement with MSD, less so with Education and the Crown Health Financing Agencies. But just the process of monitoring and engaging and having discussions with them, led to some strengthening particularly of the MSD process.I will give one example of that.

Again, the Crown was able to use its resources to contract qualified researchers to undertake research on
16.51 what were the rules, regulations, covering various institutions, what was the situation in those institutions, you know, in the 60s, 70s, what was the practice of the day? And initially, that information was denied to the claimants on the grounds of, guess what, legal privilege.

So, the Crown, and when you remember that most of the claimants were poor, most of them were legally aided, none of them would have been able to afford equivalent research to be able to challenge the research, so it was
16.51 an obvious example of complete lack of justice and we were able to, you know, point this out. And eventually, MSD made that material available I think on its website to everybody. That was just one example of kind of making the process at least a bit better.

But as the review undertook concludes, all of the processes had some flaws. And I've talked about the flaws in terms of the Terms of Reference for the Confidential Listening Assistance Service and the forum, the Psychiatric Forum.

16.52 In terms of the MSD claims resolution, the Crown Health Financing Agency and education, there was no independence at all in the way in which those services operated. The staff involved in them were outrage~~ous~~ that we should suggest that they weren't independent.

They were doing their best. But they were staff of the agency against which the claims were and, you know, they weren't going to be doing that job forever and they had to look to their future prospects.

So, even if we allow, and I do, that they were trying their best, the fact of the matter is that they couldn't possibly be seen as independent by, you know, people who had been abused by parts of that agency in the past. I mean, you know, and, I mean, although some
16.54 people had, you know, not a bad experience and they were quick to send us examples of thank you letters from people who had found it helpful and gratefully accepted the very modest amounts of compensation that were provided, it wasn't independent, it wasn't even impartial, and there were other issues associated with them but those are all in the report.

But what happened was, you know, and I feel extremely responsible for failing in this respect, what happened was when we sent the last draft around to say
16.54 I've incorporated everything you've told us, and we always sent copies to Crown Law but they never responded. In this instance, they came back saying, oh no, well, you can't publish that report, it's full of mistakes and errors and interpreting the international human rights obligations etc.

So, to cut a long story short, I organised a meeting. I offered to have a meeting with the Attorney-General. Instead a meeting was setup with at the time the Deputy Crown Solicitor and the person in
16.55 charge of the litigation strategy etc. for the Crown at Crown Law. Any rate, there were no factual errors. The two mistakes, according to Crown Law, was one that we said there was systemic issues that merited an independent Inquiry because none of these - none of the

processes actually looked at the systemic issues because they were looking at individual cases and trying to deal with those individual cases.

I was really surprised at this because I thought it was so obvious by now, there was enough evidence of the type of claims that were coming forward that clearly the whole raft of systemic issues needed to be looked at, not least, you know, management, monitoring by National Office of what went on in the regions etc., a whole lot
16.56 of things.

But when I said, I said, "What do you understand by systemic issue?" and I was told that, well, there's no, not a shred of evidence that national office, of any of the agencies, ever sent out any instructions about abusing children or mistreating them or inhumane punishment. No, they had done nothing. They had certainly not. There were no systemic issues. There were only issues that related to bad people in individual institutions at the local level. That was one thing.

16.57 The second thing related to the Convention on Torture requires an impartial process, and so they argued that. We said there was a need for an independent process and we were, as I say, misinterpreting the international requirements.

Anyhow, I think that - I mean, in order to get it published, we tweaked the wording with respect to independent and impartial, re-emphasised the fact that taken as a whole there was some good parts to all of these different, you know, so putting it in the positive,
16.58 but our recommendations were still that there needed to be both, you know, an independent Inquiry and end process for compensating people. But that was right at the end of my term as Chief Commissioner and so, we hadn't managed to have it published before I finished. In fact,

the draft you have is the one that was ready to go to the printer as I finished up. And I handed it over to my successor. I said, you know, if you prefer, it can be published in my name so you don't have to be responsible for it or it can go under your name but acknowledging that obviously it was done beforehand. And before he had a chance to do any of that, he received some very intimidating correspondence, I should say, I am trying to think of the right word for it, from the then
16.59 Attorney-General who was Chris Finlayson. And as a result of that correspondence, the report was put in the bottom drawer and never saw the light of day until Aaron Smale, the journalist who uncovered so much of this, was able to OIA it and put it back in the public arena.

So, again, I mean, I think that, you know, again, without necessarily wanting to single out a particular Attorney-General because I suspect that whoever had been there might have written the same, because of what I see as the overall trend of the government's responses, I
17.00 think again using any means to repress the government's inadequate failure to respond appropriately. And whether it's, you know, I mean, I think the public service is permeated with unduly risk averse, I think that's - you know, again, politicians have to take some responsibility for that, not just the agencies. But there's a number of issues.

So, yeah, but I think the report still has value, in terms of - and when you think, again from the evidence that Cooper Law have provided, Cooper Legal and some of
17.00 the survivors in terms of the length of time it's taken to get their cases dealt with, we're 2019 now and some of the cases, I mean, that were there in 2011 are only just being resolved now, so it's a shocking, really we should be shocked and ashamed that that's how long it has taken.

Actually, the Convention on Torture does require speedy response. So, I don't think even Chris Finlayson would claim it met that requirement.

Q. I don't want to limit you in any way but I am mindful of leaving enough time for the Commissioners to ask you questions, which I am sure they would like to do. Is there anything you would like to say on that topic before you summarise your conclusions in part 3?

A. No, I think that's enough. Of course, I am happy to
17.01 answer any questions.

Q. Of course, we will come back to any of these topics at later hearings.

A. Exactly. So, well, again, I just want to reiterate my really extraordinary respect for survivors like Keith Wiffin and others whose persistence and advocacy and courage really led to two journalists, in particular Aaron Smale and Mike Wesley-Smith undertaking such highly professional job that the whole issue of claims of abuse in State care but also, you know, faith-based
17.02 institutions, came back onto the national agenda. I mean, it really did.

And also because, as I've said to you, in terms of what, you know, how Sonja Cooper was smeared to me, I really think, you know, she deserves huge respect and admiration for persisting, and again you will have heard her, the evidence that she gave and the difficult times they went through, but persisting because without her and one or two other lawyers, again, we wouldn't be aware of what's been done in our name. And I think the efforts of
17.03 the Human Rights Commission up until 2012 and then from 2016 also contributed. And I want to acknowledge particularly Commissioner Paul Gibson and Race Relations Commissioner Dame Susan Devoy who in very difficult circumstances again advocated that something needed to

happen and persisted in that advocacy.

I think I've probably said repeatedly the State has not hesitated to use its powers and greater resources to oppose and minimise the claims of those who have been abused and ill-treated and the Courts have not been able to right the massive imbalance between the State and survivors.

I've already said my concern about the extent to which government agencies opposed the establishment of
17.04 this Royal Commission.

But they succeeded, you see. I mean, they didn't succeed completely but they did succeed in getting the Terms of Reference formally limited to 1999. And I think the challenge for this Commission is not to perpetuate that imbalance.

And it's really my observation and experience over many years that if government agencies and the Ministers are not held to account for their failures since 1999 to meet New Zealand's human rights obligations, if they are
17.05 not held to account, then nothing will change. That's the thing. They will have succeeded. They are picking up little bits here and there, tweaking this and that. It's good to see some response but actually, a lot more than tweaking is required.

When we were doing the review of the family justice services, what became clear to me was that there's still within the government sector, there is no regular systematic incorporation of New Zealand's human rights standards into the development of legislation policy and
17.05 practice. Despite, you know, the Bill of rights Act, you know, reviews that go to Parliament and some very limited circumstances, there's virtually nothing else.

So, actually, and this was true for the Convention on the Rights of the Child. These are conventions that

were ratified many years ago but still are not regularly taken into account. Sometimes somebody will discover them, you know, when the policy or the practice or the draft Bill is already drafted by which time it's usually too late to do anything substantive but that has to be an absolutely fundamental requirement, that we mainstream the human rights stance. We often let the negotiations on, we were very actively involved in the development of the Universal Declaration of Human Rights, something we
17.06 can be proud of, and of course in New Zealand diplomat-led the negotiations on the Convention on the Rights of Persons With Disabilities. And yet, despite that, despite us accepting as a State international acclamation and awards for that role, we still haven't mainstreamed the requirements of the Convention on the Rights of Persons with Disabilities, even at a most superficial level. And that puts at risk every particularly severely disabled person who needs significant levels of care, for example.

17.07 So, that's the context in which you are working and which this Royal Commission has been established. But can I just conclude by saying that I think these two weeks of contextual hearings have really already begun to make a difference. So, thank you for the way you've organised these and I'm looking forward to more of the same in the next stage because they are complex issues.

But having this public profile and people beginning to hear what's going on, I know it is already beginning to have an impact, so thank you.

17.08 **MS MOUNT:** Thank you very much for your evidence, Ms Noonan. Please wait there because there may be some more questions. If I may check with Rachel Opie who assisted with the drafting of the brief.

Thank you, Mr Chair, I haven't been advised by any

of my colleagues as co-counsel, as counsel for participants, that there are any questions but I'm sure they will bounce up if there are. Otherwise, it is a matter for you as Chair whether there are any further questions.

CHAIR: Thank you, Mr Mount. I'll go through the motions, in any event. First of all, I will ask if any counsel, despite the Practice Note to which Mr Mount has referred, is there any counsel who wishes to address questions to this witness, Rosslyn Noonan? There isn't, okay, thank you.

17.09

I then provide that opportunity for questions to be asked to my colleagues.

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ROSSLYN NOONAN

QUESTIONED BY COMMISSIONERS

COMMISSIONER ALOFIVAE: Ms Noonan, you have provided such a full and comprehensive brief. Can I thank you for that evidence. You've actually answered
17.09 the questions that I had in your brief around the level of transformation that's actually required and actually where the power lies and dot dot dot. Thank you.

COMMISSIONER GIBSON: Thanks very much, Rosslyn, that was incredibly powerful and comprehensive. I will stick to questions which I wasn't involved in.

You talked about the need for fundamental change about how the human rights standards get integrated into legislation, policy and practice. Early in the
17.10 Contextual Hearing Moana Jackson talked about the need for constitutional reform, constitutional transformation over a period of time, including Te Tiriti and international human rights standards. How do you see that linking, joining up?

A. I mean, I agree with Moana completely. I think we do need some very significant change. But I also think that the thing about New Zealand is we tend not to make dramatic changes. So, the challenge for the Royal Commission is what really substantial evolutionary
17.11 changes which will then lead on to other things, you know, can be recommended and can be encouraged and developed?

I mean, I think, you know, yeah, I think that's the answer. But a lot of it, I do think there are

fundamental changes within the State sector. I think, you know, the whole development of, well really of, I won't say devolving power, I would say sharing power with iwi Maori, I think that's - I think we're seeing some very tentative steps towards that in one or two very limited places but that needs to be the continuing approach.

And I think that within the State sector as a whole, there needs to be a review of - really of, I suppose it's
17.12 of the principles that guide the State sector and that guide, you know, I mean it seems like the public element of the public service is vanished. And that public servants, and I mean, you know, they're doing what they need to do to survive but they see their only responsibility because don't get me wrong, of course they are responsible to Ministers and they are responsible for implementing government policy, but they're seeing that as their only responsibility and not the responsibility for the wider public.

17.13 And I don't think, I mean, apart from the Secretary of Treasury, I can't think of a single senior public servant these days that you will hear a major think piece about where things should be heading. And yet, if you look back to some of our periods of really great change in New Zealand, whether in education, somebody like Dr Bebe, or if you look at, you know, the Secretary of Justice like John Robson, you can go through and identify public servants who shared thinking to help generate discussion. Whereas, now you basically have people who
17.14 are scared to recommend anything that might give rise to controversy.

That's not just their fault. That's also because of the way politicians are operating and Ministers are operating. But I think it's really dangerous for us,

particularly in an environment that's so complex, where, you know, as a society we face so many challenges. And there aren't simple answers, that's the thing. There isn't like a magic wand that you can wave and say that will fix it all, there isn't.

So, we need to have an environment where robust discussion is welcomed but we also need to have an environment - what shocked me personally has been, as I said earlier, the lack of empathy that I have witnessed
17.15 in public, senior public servants, for the victims of abuse in State care or, you know, in other circumstances. And there's something wrong where people feel that they've got to defend the State right or wrong, there's something fundamentally missing in that, that that happens.

That's why I think, I mean, if they were required to actively take account of the international human rights standards, that we have willingly signed up to, I mean that would put a different slant on things. I think it
17.15 would engender a different behaviour, a different frame of mind, and it's certainly needed absolutely, otherwise they will continue just to - the people who get into trouble are the people who deserve it, that's basically, you know, that's basically the approach now.

COMMISSIONER GIBSON: You talk about principles guiding public servants, the public service. In your statement, you refer to a human rights approach, particularly around I think it was records and the voice of the affected having a say in decisions
17.16 that affect them. Sometimes, is there a role sometimes for understanding the human rights approach, some of the principles that sit behind that, what is the role in communicating something to the public that will help transform how we care

in Aotearoa New Zealand?

A. Actually, that's a really good question. You're absolutely right.I think for too long human rights were equated with legal constitutional or legal guarantees of human rights. And human rights were seen as something that were mostly defended in Courts or could be taken to the Courts to litigate. Whereas, actually, having human rights make a difference in people's lives day-to-day. They're about how we treat each other, they're about what
17.17 opportunities we have to grow and flourish. They're about whether we've got the basics for a decent life, which includes things like healthy affordable housing and is there enough to eat? And those are - it's much more - the human rights, the impact of human rights I think is much more felt.I mean, the law is important, good to have the law, but actually it's really about what are the policies and what are the practices? A human rights approach, as you say, is really a practical way of thinking about that. You know, what are all the rights
17.18 of everybody we're looking at in a particular scenario? What are all the rights involved? How do we balance those? And the human rights approach says if you need to balance them, then they should be balanced in favour of the most vulnerable? And then how do the people who are directly affected participate in the decisions that affect them? You know, are they empowered? Is there accountability, which obviously there's been missing. And is there non-discrimination? So, these are not, it's not rocket science. And actually, again, people in the
17.18 past, you know, when we've explained this to them, with Commission's submissions and things, have said how helpful having that sort of scheme to think through things has been but it's not widespread. And, of course, one of the problems is that for the most part we don't

incorporate the whole Human Rights Covenant Convention in our legislation. Usually, there's references to it or there's bits of it that are put in but we don't put the whole Covenant or Convention say as an addendum.

In the case of the Convention on the Rights of the Child, it is included as a whole but it doesn't have a status as its own right in our law. Lots of Judges, of course, never learnt anything about human rights law, even the Bill of Rights Act, when they were in their
17.20 legal training. So, it's a new thing for them as well. There's only a few that consistently you see in their decisions are looking at what are the human rights issues here or what are the Treaty issues. So, we need more of that at every level. But I think there are some things that can be done, you know, to strengthen the law by more fully incorporating the standards as we ratify them, so they can be called on.

COMMISSIONER GIBSON: Thanks very much.

COMMISSIONER ERUETI: We are short of time, so I'll get
17.20 straight to my main question which is about redress because it was a priority for your report in 2011. And you will be aware that in 2018 there was a review carried out by MSD of the MSD historical claims process which included looking at the role of tikanga and its process, tikanga Maori.

I am wondering what you think of the - well, perhaps the best way to answer this is, whether you think that review had an impact? And also, what are the core qualities that you think are necessary for an effective
17.21 redress scheme?

A. Well, I probably - the question about what impact it's had is probably better directed at the lawyers who have been representing because I don't feel I've got enough knowledge of enough cases to make a general comment.

In the - I will quickly find it. In the report, we listed what we thought were the elements of a - yeah, so we said building on the strengths of the Confidential Listening and Assistance Service and the MSD care claims and resolution team and the lessons learnt by the direct negotiations taken by MSD and Crown Health Financing Authority, the priority must be to establish an independent and impartial in the fuller sense of the word process. To hear, investigate -

17.22 So, the process must apply to all claimants regardless of whether their claims relates to psychiatric hospitals, Social Welfare homes or institutions, foster care arrangements or education facilities. That's number one. Instead of having these disparate claims, there needs to be one process that applies.

It must be one, you know, that gives the Crown reasonable assurance that allegations have substance. So, you know, we never said people shouldn't have to provide some evidence but what has happened until now, is

17.23 that, I mean even though you've heard about Epuni, Hokio, Kohitere, Owairaka Boys etc., and we know now that even if you were not directly assaulted in one of those environments, where bullying etc. was widespread, you will have been affected as a child, seriously affected. So, you know, we're not saying that people should have to find records that show that they were actually hit but if they were in the institution at the time, where there is now overwhelming evidence of ill-treatment generally, you know, that should be sufficient.

17.24 It needs to operate fairly and demonstrate good faith. Provide claimants with access to impartial advisory service. And so, that's drawing on the sort of thing that CLAS did.

And does not leave claimants disadvantaged if

there's no settlement.

Meet the various needs of claimants, including those looking for redress other than ~~and~~ financial compensation.

And those who cannot readily take part in traditional dispute resolution processes.

Leaves open the possibility of civil litigation where there's no settlement.

Allows individuals to be prosecuted.

Is not so rigorous or time consuming as to render the process unattractive.

And uses public resources efficiently.

And we talked about drawing on international experience because one of the arguments most often used has been the fiscal risk to government. But, in fact, the Irish and Queensland responses show that you can mitigate that risk by saying this is the big bag of money, this is the bag of money, and then that has to be what's available to all of the claimants.

So, those were the kind of elements and we don't see those available as yet as a group.

COMMISSIONER ERUETI: That's right, as yet. The emphasis on independence and also the report talked about the idea of streamlining the process. Instead of going to all these different MOH, MOE ~~hui~~, MSD, it's a one stop shop?

A. Yes.

COMMISSIONER ERUETI: I understand, thank you.

A. I think there were a few other bits and pieces. All findings must be published at least in general terms etc. We did go into quite some detail about what a really good process would look like. Looking at it now, it's still possible and it's not - it shouldn't be that difficult.

COMMISSIONER SHAW: Thank you very much for your evidence, Ms Noonan. I want to thank you for your

tenacity on this issue. Your efforts go back a long way and I hope you find that at least coming here today is some sense of achievement, at least an interim achievement that we've got this far, but I think you are very much, largely responsible for the drive, so I want to acknowledge that and thank you for your evidence.

A. Thank you.

CHAIR: Thank you. I have the privilege of the final
17.27 comment. I just wish to state for the record that your own particular broad knowledge of relevant items for the Royal Commission stand alongside your courage in expressing the views that you have and what you have said and what you have provided will be of considerable interest and importance for the work of the Royal Commission, so thank you.

A. Thank you.

MR MOUNT: Mr Chair, thank you very much, thank you very much again, Ms Noonan. Tomorrow we have a 10.00
17.28 a.m. start. We have three witnesses scheduled, Mr Mike Ledingham, Professor Des Cahill and Dr Peter Wilkinson who will be the final three witnesses for this phase of the hearings.

CHAIR: Thank you, Mr Mount. We can, therefore, conclude today's proceedings by asking you, Madam Registrar, to bring Ngati Whatua into the important matter of concluding our sitting today.

(Closing waiata and karakia)

17.30

Hearing adjourned at 5.35 p.m.