

Content warning**:** This content may be distressing to read as it explores historic abuse. Please reach out if you require support.

# Executive summary

**1.** State and faith-based institutions were entrusted to care for many children, young people and adults. New Zealanders held the leaders of these institutions in the highest esteem. These leaders had a duty to nurture, protect and help people flourish. They failed in their duty.

**2.** Instead of receiving care and support, children, young people and adults in care were exposed to unimaginable physical, emotional, mental and sexual abuse, severe exploitation and neglect. Abuse and neglect were widespread throughout the Inquiry period in State and faith-based care institutions. Any abuse and neglect, let alone the prevalence of it, could not be justified by the standards of the day and certainly cannot be justified now.

**3.** Critical rights, such as those guaranteed to Māori in te Tiriti o Waitangi, and human rights, that should have protected people in care, were ignored or overlooked altogether.

**4.** Of the estimated 655,000 children, young people and adults in care from 1950 to 2019, it is estimated that up to 256,000 were abused and neglected. During the Inquiry period, 1950-1999 it is estimated around 510,000 people were in care and up to 200,000 were abused and neglected. The true number will never be fully known as records of the most vulnerable people in Aotearoa New Zealand were never created or were lost and, in some cases, destroyed.

**5.** It is a national disgrace that hundreds of thousands of children, young people and adults were abused and neglected in the care of the State and faith-based institutions. These gross violations occurred at the same time as Aotearoa New Zealand was promoting itself, internationally and domestically, as a bastion of human rights and as a safe, fair country in which to grow up as a child in a loving family. If this injustice is not addressed, it will remain as a stain on our national character forever.

**6.** This report – Whanaketia through pain and trauma, from darkness to light – shines a light on the institutional and systemic failures by recounting the experiences of people in care and their subsequent life-long pain and trauma. It sets out a path to ensure all in care are safe, cared for and supported to lead their best possible lives.

## Abuse and neglect were pervasive

**7.** Abuse and neglect almost always started from the first day a person was placed in care. It often continued the entire time a person was in care – for some people this meant years or even decades of frequent abuse and neglect. For some it was a lifetime; for others it led to an unmarked grave.

**8.** Children, young people and adults in care were regularly treated without compassion and some were wilfully neglected. There were times that babies were left in cots with no hugs, physical interaction or other expressions of care. Many survivors were denied basic necessities such as enough food and suitable clothing. Some had no privacy while bathing or using the toilet.

**9.** Tamariki, rangatahi and pakeke Māori were often targeted because of their ethnicity, and this was often overlaid with racism. The effects of colonisation continued to further keep many whānau Māori in social deprivation with resulting impacts on whānau wellbeing and financial instability.

**10.** Once in care, Māori survivors experienced harsher treatment across many settings, being degraded because of their ethnicity and skin colour. They were denied access, sometimes violently, to their ability to practice mātauranga, tikanga, reo Māori, and the ability to connect to their whakapapa, sometimes violently. For tāngata Turi Māori, tāngata whaikaha Māori, and Takatāpui survivors, these abuses were further compounded with disablism, ableism, audism and/or homophobia.

**11.** Pacific children, young people and adults in care \*\*also experienced racial abuse and cultural neglect. This included the denial of access to knowledge of their specific cultural identities, the denial of opportunities to learn about their specific culture or to speak or practise their specific cultural customs and languages; and the denial of access to, and knowledge of their kainga (family). Many also had whakapapa Māori, and they often experienced multiple and compounding forms of racial abuse and cultural neglect.  Further, they were often denied access to all their cultural identities and their associated knowledge, languages and customs.

**12.** Deaf and disabled survivors experienced ableist, disablist and audist abuse, including targeted abuse and derogatory verbal abuse. Deaf and disabled survivors, and survivors who experienced mental distress, were denied personhood and were often stripped of their dignity and autonomy. They were left unattended and ignored with no stimuli to grow or develop their individual talents or interests. Many were segregated from society, deprived of individual attention and basic educational opportunities.   Disabled adults were often treated as unable to make their own choices and decisions, with or without others’ support. Deaf survivors were denied sign language and Deaf culture. Blind survivors were denied braille.

**13.** Abusive and uncaring language, shaming and humiliation and psychological harm were used to intimidate and humiliate. Physical abuse was prevalent across all settings. In some cases, staff went to extremes to inflict as much pain as possible using weapons and electric shocks.

**14.** Staff often pitched children against each other, encouraging peer-on-peer abuse. This involved vicious attacks and humiliating rituals, which staff ignored.

**15.** Sexual abuse was commonplace in State and faith-based care settings. Abusers groomed children, young people and adults in care into trusting them. They also groomed other staff, volunteers and people in leadership positions into believing they were trustworthy, which meant that survivors who tried to disclose the abuse were not believed. Many survivors were sexually assaulted, raped and forced to perform sexual acts. Sexual abuse was used to punish and intimidate. In some cases, abusers organised the sexual abuse of survivors by trafficking them to members of the public.

**16.** Medical abuse and neglect occurred in many care settings. This included improper medical treatment and practices, misuse of medication or medical equipment and treatment without consent, including electric shocks. Chemical restraint, like sedation, was used to control behaviour and as a form of punishment in disability and mental health institutions and social welfare residences.

**17.** Women and girls were routinely tested for sexually transmitted infections and were often forced to have degrading internal vaginal examinations. Clinicians would sometimes use medical checks as an opportunity for sexual abuse.

**18.** Solitary confinement was commonly used to manage or control behaviour and as a form of punishment. In disability and mental health institutions, special schools and social welfare residences, some survivors were locked in areas with limited or no access to toilets and water.

**19.** Seclusion rooms were often cold, dark, and unhygienic. Survivors could be held for days, weeks or even months in these bleak places, where they were at risk of being sexually and physically abused by staff.

**20.** Some survivors were financially abused by their carers, including being forced to do long hours of physical labour. Survivors of disability care settings were exploited in sheltered workshops for minimal or no pay, or had their money taken by staff.

## How did this happen?

**21.** Many of the circumstances that made it more likely a child, young person or adult would enter care were often the same factors that placed them at an increased risk of abuse and neglect in care. These circumstances included being Deaf, disabled or experiencing mental distress with unmet needs, being raised in poverty and experiencing deprivation, and experiencing significant or multiple adverse childhood events. Being Māori, Pacific, or Takatāpui, Rainbow or MVPFAFF+ and experiencing discrimination was another factor. Another factor was having a deferential attitude to people in positions of authority, holding them in the highest regard, including faith leaders and medical professionals.

**22.** The people who perpetrated abuse and neglect in State and faith-based care took advantage of their positions of power over children, young people and adults in care. They were skilled at exploiting the gaps and failures in the care system. Abusers were rarely held to account for their actions or inactions, which emboldened them to perpetrate further abuse and neglect. Abusers came from all walks of life and were frequently trusted and well-regarded members of the community. Many of the institutional systems they operated in enabled abusers and institutions to abuse and neglect those in their care and act with impunity.

**23.** The State was ultimately responsible for the care system during the Inquiry period. This system was one of institutionalisation. Instead of addressing the social and cultural needs of whānau by resourcing and empowering families to care for their own, the State placed children, young people and adults in punitive, institutional settings that segregated and isolated them from their whānau and communities where they were of sight and out of mind.

**24.** Society’s discriminatory attitudes towards difference, including racism, ableism, disablism, sexism, homophobia, transphobia, punitive attitudes towards whānau and individuals who need support, all had one thing in common: they devalued and dehumanised children, young people and adults in care. This made it more likely for people in care to be abused and neglected and for that treatment to be justified by abusers, bystanders and leaders of institutions. It also made it all too easy for people in care to be ignored and forgotten by the rest of Aotearoa New Zealand.

**25.** Successive Government ministers and heads of government agencies who were responsible for the law and policy settings had accountabilities in law to children, young people and adults in their care that they failed to uphold. The State and leaders of faith-based institutions knew, or should have known, about the abuse and neglect that was happening. They failed not only in their duty to keep people in their care safe from harm, but they also failed to hold abusers to account.

**26.** Many residences and institutions developed cultures and practices that were often reflective of society’s attitudes to be punitive or to segregate those perceived as ‘other’. These dehumanised people in care and tolerated or encouraged abuse and neglect. People with military backgrounds were assumed to be appropriate to care for children, young people and adults ~~\*\*in care~~, and many brought with them a culture of command and control, punishment, physical violence and verbal abuse. Some staff, volunteers and carers who witnessed abuse and neglect became desensitised and went on to become abusers. Others were too afraid of being ostracised or losing their jobs to speak out or felt that they were powerless to do anything.

**27.** Faith-based institutions had some unique factors that contributed to abuse and neglect in their care. The assumed moral authority and trustworthiness of clergy and religious leaders allowed abusers in faith-based institutions to perpetrate abuse and neglect with impunity. Religious beliefs were often used to justify the abuse and neglect, and to silence survivors. Hierarchical and opaque decision-making processes impeded scrutiny and making complaints.

**28.** Some people making decisions about care often had little understanding and limited close connection with the children, young people and adults in their care and their communities. Care standards were inconsistent across the different care settings throughout the Inquiry period. Internal care standards, as well as those set out in law, were routinely breached. The people who worked or volunteered in care residences and institutions were often inadequately vetted, trained or supervised. Often there were staff shortages, which led to neglect and provided more opportunities for abusers to act undetected.

**29.** Only some care settings had complaints processes where children, young people and adults in care could raise concerns or disclose abuse and neglect. Very often, they were not believed or the complaint was not followed up. Senior leaders often sought to protect their own reputations and that of the residences and institutions they were responsible for. Few incidents were referred to appropriate authorities like NZ Police. Complaints were treated as employment issues or workplace incidents. In faith-based care settings, abuse was treated as a religious transgression that required survivors to forgive, let go of anger and blame, and instead embrace those who had sinned against them; and abusers to merely repent. Many abusers were relocated and went on to continue abusing people in care.

**30.** There was limited independent oversight or monitoring of State and faith-based care. Where there was oversight, it failed to consistently enforce the standards that were in place to protect people in care.

**31.** The factors that contributed to abuse and neglect in care intersected, allowing abuse and neglect to persist for decades**.**

**32.** Towards the end of the Inquiry period there were some lessons learned, particularly by the State, and changes made to legislation, policies and guidelines to enhance safeguarding and address issues identified by survivors, professionals and advocates. This included closing some institutions and involving more community-based care.But most of the factors that led or contributed to abuse and neglect during the Inquiry period continue to persist.

## Survivors paid the ultimate price

**33.** Abuse and neglect in care has had lifelong impacts on survivors. Many survivors died while they were in care or by suicide following care. For others, the impacts of abuse are ongoing and compounding, making everyday activities and choices challenging.

**34.** Separation from whānau and being told that no-one loved them – sometimes from a very young age - deprived children of their right to be loved and develop positive attachments. This has profoundly impacted how survivors view themselves and others and how they understand the world. It has impacted their ability to form stable, secure and nurturing relationships, to find and keep jobs, and to fulfil their potential.

**35.** Many survivors face reduced employment opportunities because they were denied an education. *Some* survivors were not provided with the right supports, some were not sent to school, and others were simply too traumatised by abuse and neglect to learn. Some groups have been disproportionately and distinctly impacted due to their ethnicity, circumstances, experiences and the specific types of abuse and neglect experienced while in care.

**36.** Violence was so embedded in care settings that some survivors became numb to it. Others became abusers themselves. For many survivors, their time in care was their introduction to crime and it led them to prison. Some became trapped in care and remain institutionalised today. Others progressed from prison to psychiatric care due to anti-social behaviour, substance abuse and ongoing mental distress.

**37.** Many survivors trace their current health conditions to their time in care. Survivors experienced poor physical health and enduring disability from disease and injury caused by abuse and neglect, compounded with a lack of proper treatment. Over-medicalisation has led to chronic health conditions. Gross neglect and systemic failure to provide meaningful healthcare meant some people died in care. Experiencing trauma is also associated with a range of poor health outcomes including cancer, heart disease, addiction and depression.

**38.** Survivors are often triggered by sounds, tastes and smells which remind them of the abuse and causes deep distress. Emotional impacts left many survivors feeling whakamā or shame. Eroded self-confidence and self-esteem led some survivors to self-harm, suicidal ideation, attempted suicide or suicide. Substance misuse is common.

**39.** Survivors of sexual abuse suffered immediate and lasting trauma. They have grown up with a distorted view of sexual intimacy and often have difficulty in maintaining healthy intimate relationships. Many have found it necessary to cut themselves off from this vital part of themselves altogether, leading to feelings of isolation and a profound impact on their emotional and psychological well-being.

**40.** The traumatic effect of being separated from close siblings caused survivors to feel guilt and worry about their lost brothers and sisters, and often resulted in lifelong estrangement. Abuse and neglect in care also impacted survivors’ whānau with serious consequences for subsequent generations. Survivors talked about not knowing how to parent and struggling to form close relationships, including with their own children. Children of survivors told the Inquiry about the grief of growing up with a parent who experienced abuse and neglect in care, and the damage it did to their own childhoods.

## Collective impacts

**41.** Māori have been affected by abuse and neglect in care as a collective and across generations. Taking tamariki from their whānau, iwi and hapū has meant tamariki, mokopuna and uri have been deprived of their reo, tikanga and mātauranga Māori. Generations of future Māori leaders have been lost. The trauma of the abuse has led to much larger social problems such as declining health, higher rates of incarceration, family harm, unemployment, homelessness, mental distress and substance harm, and reduced educational opportunities.

**42.** When tamariki, rangatahi and pakeke Māori were placed or taken into care, whānau, hapū, and iwi were deprived of one of their most critical roles – to exercise tino rangatiratanga over their kāinga. It removed the ability and power of whānau, hapū and iwi to care for and nurture the next generation, to regulate the lives of their people and to transfer mātauranga Māori.

**43.** Institutionalisation created a unique form of dehumanisation for Māori and Pacific Peoples due to the role that collective identity plays in socialisation, including identity development. The removal of individual and collective identity through institutionalisation was therefore culturally and spiritually abusive for many. This was also a collective abuse upon Māori collectives – hapū and iwi.

**44.** Many Pacific survivors lost their connections to their kainga, culture and language. Survivors spoke of the devastation and harm caused by cultural disconnection and the loss of cultural identity, causing harm to the vā (the ‘space between’ that holds people together) and impacting on fakatupuolamoui (the ability to live vigorously and abundantly).

**45.** For many Deaf and disabled survivors, and survivors experiencing mental distress, being segregated and experiencing restricted contact and separation from whānau and community has caused acute pain and has had lifelong negative impacts. Many were institutionalised to the extent they struggled to live independently. They were denied personhood and their culture, as well as the opportunity to practice life and community skills. Disability communities lost generations of future leaders.

**46.** Deaf survivors were denied any understanding that a Deaf culture and community existed, to which they could belong.  They were forced to communicate through speech and they were physically abused for using sign language. They did not develop language competency, resulting in a loss of confidence and access to culture and their own community leaders.

**47.** Takatāpui, Rainbow, MVPFAFF+, gender diverse and transgender survivors and their communities suffered abuse, harm and experienced hate, leading to mental distress, PTSD, suicidality, poor physical health and relationships. The impact was emotionally and socially debilitating, meant people could not be their authentic selves, and damaged their ability to thrive as communities.

**48.** Some survivors suffered trauma when they left their faith because of abuse and neglect. For some, leaving their church community meant losing their family, friends and job. Some survivors left their churches voluntarily, but others told the Inquiry they were excommunicated (forced to leave), shunned or disfellowshipped and blocked from seeing their family. The impact was a complete loss of identity, community, physical and financial assets and was emotionally devastating.

**49.** Many survivors have broken the cycle of violence and offending, creating better outcomes for their tamariki and future generations. Some have found healing by helping others, and through arts, sport and other community activities.

## Cost of abuse and neglect is too high

**50.** In addition to the profound individual and social costs to communities in Aotearoa New Zealand, the economic costs of abuse and neglect in care are very high.

**51.** The average lifetime cost to the survivor of things that New Zealanders consider normal, day-to-day activities was estimated in 2020 to be approximately $857,000.

**52.** Based on the estimated number of people abused and neglected in care between 1950 and 2019, the total cost is estimated to be between $96 billion and $217 billion. Of this the smallest proportion, up to $46.7 billion, is paid by the taxpayers of New Zealand. The largest cost, estimated at up to $172 billion, is borne by survivors.

**53.** Abuse and neglect in care has financially affected survivors, families, hapū and iwi, communities and society as a whole.  The ongoing associated intergenerational harm and trauma have contributed to social inequities as well as vast economic costs.

## Ignoring survivors for decades compounded the harm

**54.** For decades, survivors repeatedly called for justice but were unheard, disbelieved, and ignored and they were silenced. Their experiences were minimised or dismissed, and they were told abuse and neglect in care was not systemic. When they did receive recognition it was often piecemeal, insincere, and fell far short of any notions of fair redress. Even this paltry redress took years or decades to extract from the State and faith-based entities. Political and public service leaders spent time, energy and taxpayer resources to hide, cover up and then legally fight survivors to protect the potential perceived costs to the Crown, and their own reputations.

**55.** Faith leaders similarly fought to cover up abuse by moving abusers to other locations and denying culpability.

**56.** Survivors were right to call for an Inquiry.  There has been widespread abuse and neglect in State and faith-based care which has had a devastating, multigenerational impact on survivors, their whānau and society as a whole. It has been minimised and covered up by the institutions responsible. Significant resources have been used to deny survivors their voice and to defend the indefensible. This must stop.

## A safe and caring future

**57.** Survivors shared their moemoeā (dreams) for the next generation where every child, young person and adult is loved, safe and cared for in a manner that supports their growth and development into a thriving contributor to society.
**He moemoeā ō ngā purapura ora mote heke mai Survivors’ dreams for the future**

**1.** Aotearoa New Zealand’s care system is broken.  Survivors want to see a total overhaul and fundamental change to ensure that this national catastrophe does not continue.

**2.** Survivors told the Inquiry that the care systems need to fundamentally change. This would see the State handing over power, funding and control of preventative supports and care services to local communities and communities of interest.

**3.** Survivors want every whānau supported so they can provide loving care themselves. That means they must receive the supports they need, when they need these and for as long as needed, to realise their full potential and flourish. Additional daily care support may be required to avoid out-of-whānau care.  Faith-based institutions would exit the business of care and in their pastoral care adopt national standards and transparent complaint processes.

**4.** From time to time, out-of-whānau care will be required. When out-of-whānau care is required, it must be short-term. It must be delivered by the community, hapū or collective and the individual and their whānau have control of decisions on care.  Out-of-whānau care should only be used to give the wider whānau time to receive holistic support, for example for healing or resetting, so they can be brought back together. Everyone in the community works to return that child home. Out-of-whānau care will be in plain sight, with children safeguarded in multiple ways and wider whānau/family connections maintained at all times.

**5.** Local schools are welcoming and inclusive of all students and all students have their diverse needs met and achieve to their potential.  Children, young people and adults receive the disability or mental health supports they need.

**6.** The Crown must cede authority and live up to the promise of te Tiriti o Waitangi. Whānau, hapū and iwi must be able to exercise their right to tino rangatiratanga over kāinga and are empowered to care for their tamariki, rangatahi, pakeke and wider whānau according to their tikanga and mātauranga. The mana of all individuals, communities and whānau must be restored.

**7.** Human rights are respected, made real, and embedded into law to support people to avoid out-of-whānau care and give greater protection to people who may require care of their choice in the community.

**8.** In faith-based institutions, leaders providing pastoral care reflect the diversity of their communities and expression of that diversity is welcomed. Respect for te Tiriti o Waitangi, human rights for all people and freedom of belief simultaneously flourish.  Faith community members are free to choose partners, seek appropriate health care and have no fear of being shunned.

**9.** Communities, hapū and iwi must be enabled and empowered to design, implement, innovate and control how the care systems operate for their community. The Government should invest in communities that have levels of social deprivation,  support communities to identify those in need, understand the evidence of what works to prevent the need for a care intervention, take an early investment approach and measure long-term outcomes in communities.

**10.** Survivors spoke in detail about local communities defining the preventative work, support services and out-of-whānau care. Survivors and whānau took the Inquiry to examples in the community where this is happening – where hapū provide a full preventative service to whānau.

**11.** Survivors acknowledge that devolving power, funding and control from the State into local hands will take time. It will require several stepping stones to get there. Some local communities or communities of interest will be ready now, so these steps can be taken immediately.  Others will need extra support and investment before they can take on new or expanded roles in providing services and supports.

**12.** Most significantly, survivors want the State to radically change its attitude and practices relating to care decision-making and investment, which are characterised by low trust and a focus on risk aversion and crisis response rather than empowering whānau and local communities to look after their own.

## Summary of Inquiry’s recommendations

**58.** Survivors’ moemoeā are the foundation of the Inquiry’s vision for the future – he Māra Tipu (a growing garden) and at the heart of the Inquiry’s recommendations. The State and faith leaders must right the wrongs of the past, the care system must be made safe for every child, young person and adult in care, and Aotearoa New Zealand must entrust, empower and invest in whānau and communities to care for their loved ones.

## State and faith leaders must right the wrongs of the past

**59.** Survivors are united in calling for State and faith leaders to make public apologies and take accountability for the harm caused to children, young people and adults. This includes the Prime Minister and faith leaders, but it goes much deeper. All public sector leaders, leaders of relevant professional bodies, leaders of care providers and leaders of faith-based institutions need to apologise to survivors publicly.

**60.** An apology is hollow without change. With urgency, State and faith-based institutions must implement the Inquiry’s 2021 recommended puretumu torowhānui system and scheme. There must be no further delay.

**61.** Aotearoa New Zealand must not put survivors through further hurt. The courts should prioritise civil proceedings regarding care or abuse and neglect in State or faith-based care to minimise litigation delays.

**62.** Additionally, NZ Police should establish a specialist unit dedicated to investigating and prosecuting those responsible for historical and/or current abuse and neglect in State and faith-based care.

## Make every child, young person and adult safe in care today

**63.** Aotearoa New Zealand must do everything in its power to make sure that our care system is safe for every child, young person and adult. This will require political leadership on preventing and responding decisively and effectively to abuse and neglect in care.

**64.** Critically, complaints need to be listened to, investigated and acted on in a timely manner to keep children, young people and adults in care safe. Leaders within the care system must prioritise safeguarding and be held accountable for any failures.

**65.** The care workforce must be valued and invested in. They provide care and aroha to our most vulnerable children, young people and adults. This workforce needs to be thoroughly screened, accredited and trained, and provided with good working conditions and pay. The care work force should reflect the diversity of people in care and include care-experienced workers.

**66.** The government should take all the measures within its power to shift from the State and faith providing care to empowering communities to provide care whilst maintaining connection to whānau. Residences and institutions will never deliver ‘care’; nor can they ever replace a loving parent or caregiver.

## Entrust, empower and invest in whānau and communities

**67.** Everyone in Aotearoa New Zealand has a part to play in preventing abuse and neglect in care. Everybody needs the knowledge and tools to achieve this, so that the beliefs that contribute to harmful and discriminatory experiences in care can be eliminated, and abusers can be identified and stopped.

**68.** All whānau must be invested in so they can care for their loved ones, with support from the community and funding by the State. Poverty and deprivation must be addressed. Accessibility, disability and mental health supports are required. If out-of-whānau care is required, institutional environments and practices must be eliminated and communities supported to care for their own.

**68.** All entities must uphold te Tiriti o Waitangi and the rights of Māori in care as Indigenous peoples of Aotearoa New Zealand, and act consistently with New Zealand’s international human rights obligations.