Abuse in Care
Royal Commission of Inquiry

PART 6

JUNE 2024

Whanaketia

Te Tiriti o Waitangi and Human Rights

Te ture i raurangi rā

THROUGH PAIN AND TRAUMA, FROM DARKNESS TO LIGHT

Presented to the Governor-General by the Royal Commission of Inquiry into
Historical Abuse in State Care and in the Care of Faith-based Institutions

ISBN 978-0-473-71009-5 (print)
ISBN 978-0-473-71010-1 (online)

Whakairihia ki te tihi o Maungārongo

He karakia

E tāmara mā, koutou te pūtake o ēnei kōwhiringa, kua horaina nei
E tohe tonu nei i te ara o te tika
E ngaki tonu ana i te māra tipu
Anei koutou te whakairihia ki te tihi o
Maungārongo, kia tau te mauri.

Rukuhia te pū o te hinengaro
kia tāea ko te kukunitanga mai o te whakaaro nui.
Kia piere ko te ngākau mahora
kia tūwhera mai he wairua tau.

Koinei ngā pou whakairinga i te tāhuhu
o te Whare o Tū Te Mauriora.
Te āhuru mōwai o Te Pae o Rehua,
kaimuru i te hinapōuri,
kaitohu i te manawa hā ora,
kaihohou i te pai.

Nau mai e koutou kua uhia e ngā haukino
o te wā, kua pēhia e ngā whakawai a ngā tipua nei,
a te Ringatūkino rāua ko te Kanohihuna.

Koutou i whītiki i te tātua o te toa,
i kākahu i te korowai o te pono,
i whakamau i te tīpare o tō mana motuhake,
toko ake ki te pūaotanga o te āpōpō e tatari mai nei i tua o te pae,
nōu te ao e whakaata mai nei.

Kāti rā, ā te tākiritanga mai o te ata,
ā te huanga ake o te awatea,
kia tau he māramatanga,
kia ū ko te pai, kia mau ko te tika.
Koinei ko te tangi a te ngākau e Rongo,
tūturu ōwhiti whakamaua
kia tina, tina!
Hui e, tāiki e!

– Waihoroi Paraone Hōterene

To you upon whom this inquiry has been centered
Resolute in your pursuit of justice
Relentless in your belief for life
You have only our highest regard and respect,
may your peace of mind be assured.

Look into the deepest recesses of your being
and discover the seeds of new hope,
where the temperate heart might find solace,
and the blithe spirit might rise again.

Let these be the pillars on which the House of Self,
reconciliation can stand.
Safe haven of Rehua,
dispatcher of sorrow,
restorer of the breath of life,
purveyor of kindness.

Those of you who have faced the ill winds
of time and made to suffer,
at the hands of abusers and the hidden faces of persecutors, draw near.

You who found courage,
cloaked yourselves with your truth,
who crowned yourself with dignity,
a new tomorrow awaits beyond the horizon,
your future beckons.

And so, as dawn rises, and a new day begins,
let clarity and understanding reign,
goodness surrounds you and
justice prevails.
Rongo god of peace, this the heart desires,
we beseech you,
let it be,
it is done.

– Waihoroi Paraone Hōterene

Te ture i raurangi rā

The title for this Part refers to the third line of the waiata that refers to those that were abandoned by justice and order, by the laws and agreements that were meant to protect and care for them, including Te Tiriti o Waitangi and Human Rights.

Pānui whakatūpato

Ka nui tā mātou tiaki me te hāpai ake I te mana o ngā purapura ora I māia rawa atua nei ki te whāriki I ā rātou kōrero ki konei. Kei te mōhio mātopu ka oho pea te mauri ētahi wāhanga o ngā kōrero nei e pā ana ki te tūkino, te whakatūroro me te pāma-mae, ā, tērā pea ka tākirihia ngā tauwharewarenga o te ngākau tangata I te kaha o te tumeke. Ahakoa kāore pea tēnei urupare e tau pai ki te wairua o te tangata, e pai ana te rongo I te pouri. Heoi, mehemea ka whakataumaha tēnei i ētahi o tō whānau, me whakapā atu ki tō tākuta, ki tō ratongo Hauora rānei.Whakatetia ngā kōrero a ētahi, kia tau te mauri, tiakina te wairua, ā, kia māmā te ngākau.

Distressing content warning

We honour and uphold the dignity of survivors who have so bravely shared their stories here. We acknowledge that some content contains explicit descriptions of tūkino – abuse, harm and trauma – and may evoke strong negative, emotional responses for readers. Although this response may be unpleasant and difficult to tolerate, it is also appropriate to feel upset. However, if you or someone in your close circle needs support, please contact your GP or healthcare provider. Respect others' truths, breathe deeply, take care of your spirit and be gentle with your heart.

Ngā take

Contents

Kuputaka
Glossary

Term	Explanation
autonomy	Self-government, or the capacity to make an informed, uncoerced decision.
bodily integrity	The right to make decisions about your own body and the idea that our bodies belong only to ourselves.
cultural capability	Having the skills, knowledge, behaviours and systems to deliver an experience in a culturally respectful and appropriate way.
detribalising	Removing someone from a traditional tribal social structure.
indivisibility	The idea that something or someone is not able to be separated from its essential parts.
kāinga	A reo Māori term for traditional village habitation.
kāwanatanga	A reo Māori term, an adaptation of the English word 'governor'.
kaupapa Māori	A reo Māori term for Māori approach, Māori topic, Māori customary practice, Māori agenda, Māori principles, Māori ideology – a philosophical doctrine incorporating the knowledge, skills, attitudes and values of Māori society.
mana motuhake	A reo Māori term for enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.
mātauranga Māori	A reo Māori term for Māori knowledge. It's a modern term that broadly includes traditions, values, concepts, philosophies, worldviews and understandings derived from uniquely Māori cultural points of view. It traverses customary and contemporary systems of knowledge.
mental distress	A mental or emotional state that causes disruption to daily life and that can vary in length of time and intensity.
mental integrity	The right against mental interference.
monocultural	Describes a way of life, worldview, where attitudes and behaviours consists of one dominant group and culture.

Term	Explanation
neuroleptics	Antipsychotic medications used for the treatment and management of symptoms associated with various psychiatric disorders.
paternalistic policies	Policies that limit a person or group's liberty or autonomy and are intended to promote their own good.
psychopaedic	Outdated Aotearoa New Zealand term to distinguish people with a learning disability from people experiencing mental distress.
self-determination, including for indigenous peoples	The right to form a political entity.
societal and systemic racism / structural racism	A form of indirect discrimination as it occurs when an action, omission, or policy that appears to treat everyone in the same manner, actually creates negative effects unfairly impacting a particular group.
tāngata Turi Māori	A reo Māori term for a person who is Māori and Deaf and may include those who are hard of hearing.
tāngata whaiora Māori	A reo Māori term for people who are seeking health. It can also be used to refer to a person receiving assessment and treatment in mental health, addiction and intellectual disability services.
tikanga Māori	A reo Māori term for behavioural guidelines for living and interacting with others in ao Māori.
tino rangatiratanga	A reo Māori term for self-determination, sovereignty, independence and autonomy.
universality	The idea that all people have equal human rights, whoever they are and wherever they live, regardless of their status or characteristics.
urbanisation	Population shift from rural to urban areas.
whānau hauā Māori	A reo Māori term for a person with disabilities, which reflects te ao Māori perspectives and collective orientation.

"The reports
on my file from my
time at Kohitere state I was
coping well and using my time
constructively. This is not my
recollection. I left with a fierce hatred
for the world and the system,
and no empathy or self-worth.
Kohitere stole my mana."

POI MCINTYRE
Māori (Ngāi Tahu)

Ūpoko | Chapter 1
He whakataki
Introduction

1. In Part 1 of this report, the Inquiry set out its te Tiriti o Waitangi framework and the core human rights themes that have guided the Inquiry's work as provided for in clauses 3 to 4 and 6 to 8 of the Inquiry's Terms of Reference. This Part explores the evidence and information collated through these lenses and enables the Inquiry to set out its general comments, consistent with clause 31 of the Inquiry's Terms of Reference, on these matters.
2. Chapter 2 of this Part focuses on applying the Inquiry's te Tiriti o Waitangi framework.
3. Chapter 3 focuses on applying the Inquiry's human rights themes.
4. Chapter 4 summarises the Inquiry's conclusions. In doing this, the Inquiry recognises that it is not its role to determine liability (that is, whether legal rights or obligations were breached).[1] That is a role for the courts or other bodies with appropriate powers. In particular, courts have a key role in determining whether a particular act or omission meets legal tests, and whether the government or another organisation is legally responsible for that act or omission.
5. The Inquiry is not a court, and its procedures are not suitable for making findings of legal liability. Also, over the Inquiry period the nature of human rights has changed. This has included the change from the rights in the Universal Declaration of Human Rights being a common standard of achievement to many of those rights becoming legally binding on Aotearoa New Zealand after it joined international human rights treaties.[2] In addition, the content of human rights has developed over the Inquiry period. That can make it difficult to be certain about how human rights were understood at particular time periods. There are issues, too, about the extent to which faith-based organisations can be said to have had human rights obligations.

1 Inquiries Act 2013, section 11(1).
2 Aotearoa New Zealand ratified the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights in 1978.

6. Those matters noted, the Inquiry's terms of reference provide that the Inquiry must make general comments, findings, or both, about the nature and extent of abuse and neglect that occurred in State and faith-based care during the Inquiry period.[3] The Inquiry can also make findings of fault and findings that relevant standards have been breached, and the Inquiry can recommend that further steps be taken to determine liability.[4]

3 Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018, clauses 10.1 and 31(a).
4 Inquiries Act 2013, section 11(2), and Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018, clause 33.

Ūpoko | Chapter 2
Te arotake ki te Tiriti o Waitangi
Te Tiriti o Waitangi

Te anga Tiriti o Waitangi o te Pakirehua
The Inquiry's te Tiriti o Waitangi framework

7. While the Inquiry considers that the application of te Tiriti o Waitangi is always contextually dependent, te Tiriti o Waitangi is relevant to both the Crown itself (directly and indirectly) as well as other institutions (including faith-based institutions) that provide care for tamariki, rangatahi and pakeke Māori.

8. The approach that the Inquiry has taken to the relevance of te Tiriti o Waitangi to the Crown and institutions is that:

   (a) The Crown has obligations as a te Tiriti partner and signatory to te Tiriti that includes:[5]

   - Ensuring the Crown and institutions recognise Māori rights and values.
   - Ensuring the Crown and institutions act in accordance with te Tiriti o Waitangi obligations of the Crown.
   - Monitoring the activities of institutions, and auditing institutions' performance in the context of te Tiriti o Waitangi relationship between Crown and Māori.

   (b) Institutions are not necessarily te Tiriti o Waitangi partners themselves, but:

   - Legislation may require institutions to act consistently with te Tiriti o Waitangi.[6]
   - Te Tiriti o Waitangi is relevant to interpreting legislation even where legislation is silent on te Tiriti o Waitangi.[7] Given tamariki, rangatahi and pakeke Māori are taonga, te Tiriti o Waitangi o Waitangi colours all legislation dealing with the status, future and control of tamariki, rangatahi and pakeke Māori.[8]

5 See Waitangi Tribunal, Tauranga Moana 1888–2006: Report on the Post-Raupatu Claims (Wai 215), (2010, page 476).
6 See Education and Training Act 2020, sections 4, 5, 9 and 127.
7 See Trans-Tasman Resources Ltd v Taranaki-Whanganui Conservation Board [2021] 1 NZLR 801, [2021] NZSC 127 (paras 8 and 151); Ngāti Whātua Ōrākei Trust v Attorney-General [2022] NZHC 843, page 589; and Huakina Development Trust v Waikato Valley Authority [1987] 2 NZLR 188 (HC).
8 Barton-Prescott v Director-General of Social Welfare [1997] 3 NZLR 179 (page 184).

- If institutions made their own commitments to te Tiriti o Waitangi (for example, in governing documents of public statements), they may be held accountable to meet those commitments (for example, the Ministry of Health's policy commits it to exercise its powers in accordance with te Tiriti, however it may be arguable that faith-based institutions exercise public powers and functions when providing care and therefore could be amenable to judicial review if a decision is inconsistent with its own te Tiriti commitments).[9]

9. In terms of what te Tiriti o Waitangi requires, the Inquiry draws on the significant body of jurisprudence developed by the Waitangi Tribunal and courts over the past 40 years. While the Inquiry draws on certain te Tiriti o Waitangi principles, the Inquiry acknowledge that these principles cannot be divorced from, and necessarily include, the articles and language of te Tiriti o Waitangi.

Te whakamahi i ngā mātāpono o Te Tiriti o Waitangi
Application of te Tiriti o Waitangi principles

10. As set out in Part 1, the Inquiry is underpinned by te Tiriti o Waitangi principles that apply in relation to the care of tamariki, rangatahi and pakeke Māori:

    (a) tino rangatiratanga
    (b) kāwanatanga
    (c) partnership
    (d) active protection
    (e) options
    (f) equity and equal treatment
    (g) good government
    (h) redress.

9 See Te Pou Matakana Limited v Attorney-General [2022] 2 NZLR 148, [2021] NZHC 2942.

Te aukati i te mana me te rangatiratanga o ngā hapū me ngā iwi
Denial of hapū and iwi mana and autonomy

11. Tamariki, rangatahi and pakeke Māori were often taken, or placed into care. This means whānau, hapū, and iwi were deprived of one of their most critical roles – to exercise tino rangatiratanga over their kāinga. It also denied hapū and iwi the ability to exercise mana motuhake and autonomy in relation to tamariki, rangatahi and pakeke Māori. It removed the ability and power of whānau, hapū and iwi to care for and nurture the next generation and to regulate the lives of their people. Had whānau Māori been able to fully realise the exercise of their tino rangatiratanga and mana motuhake as envisaged by te Tiriti o Waitangi, tamariki, rangatahi and pakeke Māori would not have needed care from the State or faith-based institutions in the first place and those who did need care (outside of their whānau) would be served by their hapū, iwi or hāpori Māori.

Te kore anganui ki ngā pānga toronaha moroki o te tāmitanga
Failure to address the ongoing systemic effects of colonisation

12. Many whānau Māori are in vulnerable situations at least in part because of the ongoing systemic effects of colonisation including the alienation from whenua, whānau, and whakapapa.

13. Viewing the issue of care and protection in the historical context of Aotearoa New Zealand, there are many policies and laws over successive governments that were either directed at or had the effect of suppressing tribal political institutions. This included the taking of tribal territory (through direct purchase, land confiscation and Māori land legislation) that disconnected Māori from their economic, political, social and cultural base. As articulated best by Dr Moana Jackson: "A people cannot be tangata whenua if they have no whenua to be tangata upon."[10] State policies of assimilation devalued Māori language and culture. The urbanisation push, particularly in the mid-1950s to 1970s, further fractured Māori communities.

14. Since 1840 State policies, practices and laws have played a direct and active role in detribalising Māori communities, denying Māori rangatiratanga and creating the underlying factors that have contributed to tamariki Māori, rangatahi Māori and pakeke Māori being taken into care.

10 Brief of evidence of Dr Moana Jackson at the Inquiry's Contextual Hearing (Royal Commission of Inquiry into Abuse in Care, 29 October – 8 November 2019, para 44).

15. The State failed to address the ongoing systemic impacts of colonisation that contributed to Māori being taken into care, in which Māori experienced abuse and neglect. This includes recognising the inherent mana motuhake of iwi and hapū, structural reform that would have enabled Māori to exercise rangatiratanga and mana motuhake. Further, when the State was alerted to whānau experiencing stress (whether through for example poor health outcomes, lack of adequate housing, due to circumstances where alcohol and drugs were prevalent), accessible and practical support to whānau to avoid the removal of tamariki, rangatahi and pakeke Māori from whānau was not provided, nor opportunities for whanaunga (kin relatives) in hapū and iwi or hāpori Māori to be supported to provide assistance. Grainne Moss, who was chief executive of Oranga Tamariki at the time of the urgent Waitangi Tribunal inquiry into Oranga Tamariki in 2021, confirmed:

"Historically, Māori perspectives and solutions have been ignored by the care and protection system."[11]

16. The failure to address the broader underlying issues that create the circumstances in which Māori are disproportionately taken into the care of State and faith-based institutions was a breach of the Crown's duties to recognise rangatiratanga and actively protect Māori.

Nā ngā pūnaha taurima ā-Kawangatanga, ā-whakapono hoki, i whakararu ai te whānau ki te tiaki i ō rātou uri

State and faith-based care undermined the ability of whānau to care for their own

17. The Crown act of removing Māori from their whānau, hapū and iwi and placing them in various care settings was an act of ongoing colonisation and structural racism. Not only did the taking of tamariki Māori, rangatahi Māori and pakeke Māori undermine whānau and hapū and tribal structures but in some cases Māori who have been in care do not even know where they come from. This has created a landscape of cultural devastation for many Māori survivors.

11 Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry, Pre-publication version (Wai 2915), (2021, page 5).

18. Although the removal of Māori from their whānau was framed within the guise of 'protection' and 'care', it occurred within a context of discriminatory, paternalistic and racist policies which sought to assimilate Māori into dominant Pākehā society. Māori were also generally targeted by NZ Police, social workers and other State officials and the intrusion into the sphere of tino rangatiratanga was often violent and abusive for individuals and their whānau, hapū and iwi. Structural racism has been acknowledged by former Oranga Tamariki Chief Executive Grainne Moss as a feature of the State care system,[12] which has also been reflected in society more generally, leading to more tamariki and rangatahi Māori being reported and coming to the attention of NZ Police, social workers and other State officials. The Adoption Act 1955 stripped away and legally severed many Māori from their whakapapa.

19. The taking of Māori into care was an intrusion into the tino rangatiratanga sphere and undermined the ability of Māori to exercise their right to care for their own supported and enabled by hapū, iwi and communities more broadly. It was also a breach of the legitimate exercise of kāwanatanga (which requires the Crown to foster rangatiratanga and ensure laws and policies were just, fair and equitable) and the principles of partnership and active protection.

Te aukati i te Māori i ngā take whakatau me te whakaaweawe
Exclusion of Māori from decision making and influence

20. Like the Waitangi Tribunal in its He Pa Harakeke Report,[13] the Inquiry found little evidence of te Tiriti o Waitangi partnership or meaningful Māori involvement in the design and implementation of Crown policy and legislation relating to the care of children during the Inquiry period.

21. Whānau, hapū and iwi had little, if any, voice or role in decision making processes across the spectrum of care systems, including the placement of tamariki Māori. Māori were locked out of decision making about the best interests and wellbeing of their taonga. Further, there was a limited understanding of te Tiriti o Waitangi, which has allowed or enabled a selective approach to incorporating or implementing te Tiriti in practices, standards, polices and legislation.

12 Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry, Pre-publication version (Wai 2915), (2021, page 5).
13 Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry, Pre-publication version (Wai 2915), (2021, page 18).

22. The absence of Māori thought, input, autonomy and influence within the State and faith-based care systems was a breach of te Tiriti o Waitangi particularly the right of Māori to exercise tino rangatiratanga over their kāinga. This resulted in Māori being unable to intervene and protect their own from entry into care and from suffering abuse and neglect while in care. It resulted in the safety of Māori not being met. It was also a breach of the te Tiriti partnership and the Crown's duty of active protection.

Te aukati i ngā anga taurima Māori
Exclusion of Māori models of care

23. The State and faith-based care systems was generally Eurocentric. Māori models of care that valued te ao Māori, mātauranga Māori, tikanga Māori, te reo, and retaining connections to culture and whānau were either excluded from this system until mid-1980s. The Inquiry observed that:

    a) The placement of Māori in Pākehā psychiatric hospitals undermined Māori concepts of health, wellbeing and care.

    b) Tāngata Turi Māori did not have the option of learning sign language in te reo Māori and therefore were unable to connect to their culture and whakapapa through their language.

    c) It was not an option for whānau, hapū, iwi or hāpori Māori to receive support to be empowered to care for their whānau hāua, tangata whaiora and tāngata Turi in a culturally appropriate way at home.

    d) Whānau, hapū or iwi did not have the option to be involved in the care of tamariki, rangatahi and pakeke Māori that were placed or taken into specialised care settings.

24. From the mid-1980s onwards there were some limited attempts made to include te ao Māori, tikanga Māori and te reo Māori.

25. The care systems into which Māori were taken and placed generally took a Eurocentric, 'one size fits all' approach that was culturally inappropriate for Māori. Māori thinking, approaches and values were not incorporated into the care systems for tamariki, rangatahi and pakeke in care. The lack of kaupapa Māori options as part of the care systems fall foul of te Tiriti o Waitangi principle of options, that follows on from the principles of partnership, active protection, and equity.

Te tīhoretanga o te tuakiri ahurea i te Māori me te kaikiritanga
The stripping away of Māori cultural identity and racism

26. Once in care, survivors suffered many forms of abuse and neglect. Māori survivors emphasised the overt and targeted racism they endured, the cultural neglect and the deliberate stripping away of Māori survivors from their culture, language, and identity in both state and faith-based care, and the legal severance from their whakapapa for those Māori that were adopted.

27. Cultural genocide as defined by international law is the systematic destruction of traditions, values, language, and other elements that make one group of people distinct from another.[14] While the Inquiry has not found a particular policy that expresses cultural genocide as a goal or intention of the care system, Māori have been disproportionately targeted, removed from their culture and placed into care systems that have not prioritised or provided for their traditions, values, and language. When tamariki, rangatahi and pakeke Māori were taken into care, this action also meant that the whānau, hapū and iwi lost their chance to perpetuate the transmission of mātauranga (knowledge), tikanga and te reo Māori, and collective identity to those tamariki, rangatahi and pakeke Māori. The Waitangi Tribunal has also found that Crown care policies have been dominated by efforts to assimilate Māori to the Pākehā way and that this is perhaps "the most fundamental and pervasive breach of te Tiriti o Waitangi / the Treaty and its principles".[15] The Inquiry agrees with this line of reasoning.

28. Care systems were part of the ongoing effect of colonisation. There is a serious question whether aspects of the care system contained elements of cultural genocide. Both the 1997 Australian Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families[16] and Canada's Truth and Reconciliation Commission inquiring into its residential school system found cultural genocide through its aboriginal policy, specifically its policies of assimilation.[17] In Aotearoa New Zealand the laws and practices of removing tamariki, rangatahi and pakeke Māori involved elements of both systemic racial discrimination and cultural genocide. The denigration and stripping away of Māori cultural identity as part of a broader system of assimilation was inconsistent with the principles of tino rangatiratanga, kāwanatanga, partnership, active protection and equity.

14 Truth and Reconciliation Commission of Canada, Honouring the truth, reconciling for the future: Summary of the final report of the Trust and Reconciliation Commission of Canada (2015, page 1).
15 Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry, Pre-publication version (Wai 2915), (2021, page 12).
16 National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, Bringing them home (1997).
17 Truth and Reconciliation Commission of Canada, Honouring the truth, reconciling for the future: Summary of the final report of the Trust and Reconciliation Commission of Canada (2015, page 1).

Te taraweti ki te reo Māori
Hostility towards the use of te reo Māori

29. The care system had a hostile attitude towards the use and retention of te reo Māori. Te reo Māori was not something that was prioritised and valued; some Māori names of tamariki, rangatahi and pakeke Māori were removed and in some instances survivors were punished for speaking te reo. This impacted not only the individual survivors but for some was a break with their whakapapa and whānau and has had an intergenerational impact.

30. The hostility towards the use of te reo Māori in the care system and resulting loss of language breached the te Tiriti o Waitangi principle of active protection.

Nā te kore te tika o te tiaki kīhai i haumaru te Māori
Inadequate care failed to keep Māori safe

31. Māori survivors suffered a range of abuse and neglect across care settings, including psychological, emotional, physical, sexual, cultural, educational, medical, and spiritual abuse and neglect, on top of the effects of colonisation and urbanisation. Māori survivors shared their experiences of transgressions to their personal tapu, mana, mauri and wairua from abuse and neglect in care.

32. While the Inquiry has not been able to obtain accurate numbers around abuse, it is evident that abuse was prolific and that Māori have long made up the majority of those in placed in social welfare and youth justice care settings. The number of Māori abused in care is therefore likely to have been pervasive and disproportionate. Further, being Māori was likely to make the impact of the abuse and neglect worse for survivors.

33. There are multiple systemic reasons why many Māori suffered multiple forms of abuse and neglect while in care or received inadequate care. Quite simply, the care system was broken. Contributing factors are set out in Part 7 of this report and include a lack of resourcing, a lack of action when abuse was raised, a lack of effective protection policies, a violent institutional culture, a lack of prioritisation of Māori values, inadequate cultural capability and societal and systemic racism being deeply embedded within the care system.

34. Tamariki, rangatahi and pakeke Māori in care are taonga. While assuming ultimate care and responsibility or an oversight role for these taonga, the Crown failed to protect or prevent the abuse that many suffered. This is a grave breach of the Crown's obligation under te Tiriti o Waitangi to actively protect Māori as well as those institutions who have te Tiriti o Waitangi obligations. That disparities in abuse are likely to be present and that Māori are disproportionately affected by racism is also a breach of the principle of equity and equal treatment. Further, the Crown was or should have been aware of the abuse and neglect suffered by Māori while in care. This raises concerns that the Crown has breached the principle of good government particularly by failing to adequately care for Māori or obtain and maintain adequate information or knowledge of any abuse or neglect suffered by Māori while in care, or hold abusers to account.

Te kore tuku rongoā mō te tūkino me te whakahapa
Failure to provide a remedy for abuse and neglect

35. Many survivors found their efforts to have their abuse and neglect appropriately acknowledged and to receive reasonable redress from the State and faith-based institutions for that abuse and neglect, were often rejected or in some instances limited to a small financial payment. The failings in the redress system for abuse and neglect in care are covered in our interim report He Purapura Ora: he Māra Tipu.[18] These failings included redress processes not being developed with regard to te Tiriti o Waitangi, not recognising the mana of survivors or offering genuine support for survivors to heal their lives and not including tikanga Māori or reflecting te ao Māori concepts and values and the need for collective redress.

36. More broadly than the shortcomings in the redress process, it is clear the Crown has acted in excess of its kāwanatanga powers and breached te Tiriti in a number of ways. The Crown failed to transform the care system in a manner that would uphold rangatiratanga and reflect a true partnership.

37. The failure to implement a te Tiriti o Waitangi consistent redress process for abuse and neglect in care and the ongoing failure of the Crown to address its breaches in respect of the care system more broadly (which leads to abuse and neglect) is a failure to uphold the principle of redress.

18 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui (2021).

Ngā pāpātanga tukuiho ki ngā kiritōpū
The intergenerational impact on collectives

38. The impact of abuse on survivors transcends the individual. The impact of the removal of Māori from their cultural communities, particularly in great numbers, created a significant loss of those who could maintain and continue cultural skills.

39. The trauma of the abuse suffered by those in care was intergenerational and collective. That is, it transferred from survivors to their tamariki, mokopuna, whānau, hapū, and iwi. This can manifest itself in many ways. That includes a number of social problems such as inequitable health and education outcomes, higher incarceration rates, gang formation, intimate partner violence and family and whānau violence, unemployment, homelessness, mental distress, substance misuse and abuse, an overall narrowing number of life opportunities, and suicide. Part 5 discusses these impacts in more detail.

40. This category of harm also breaches the te Tiriti principle of active protection.

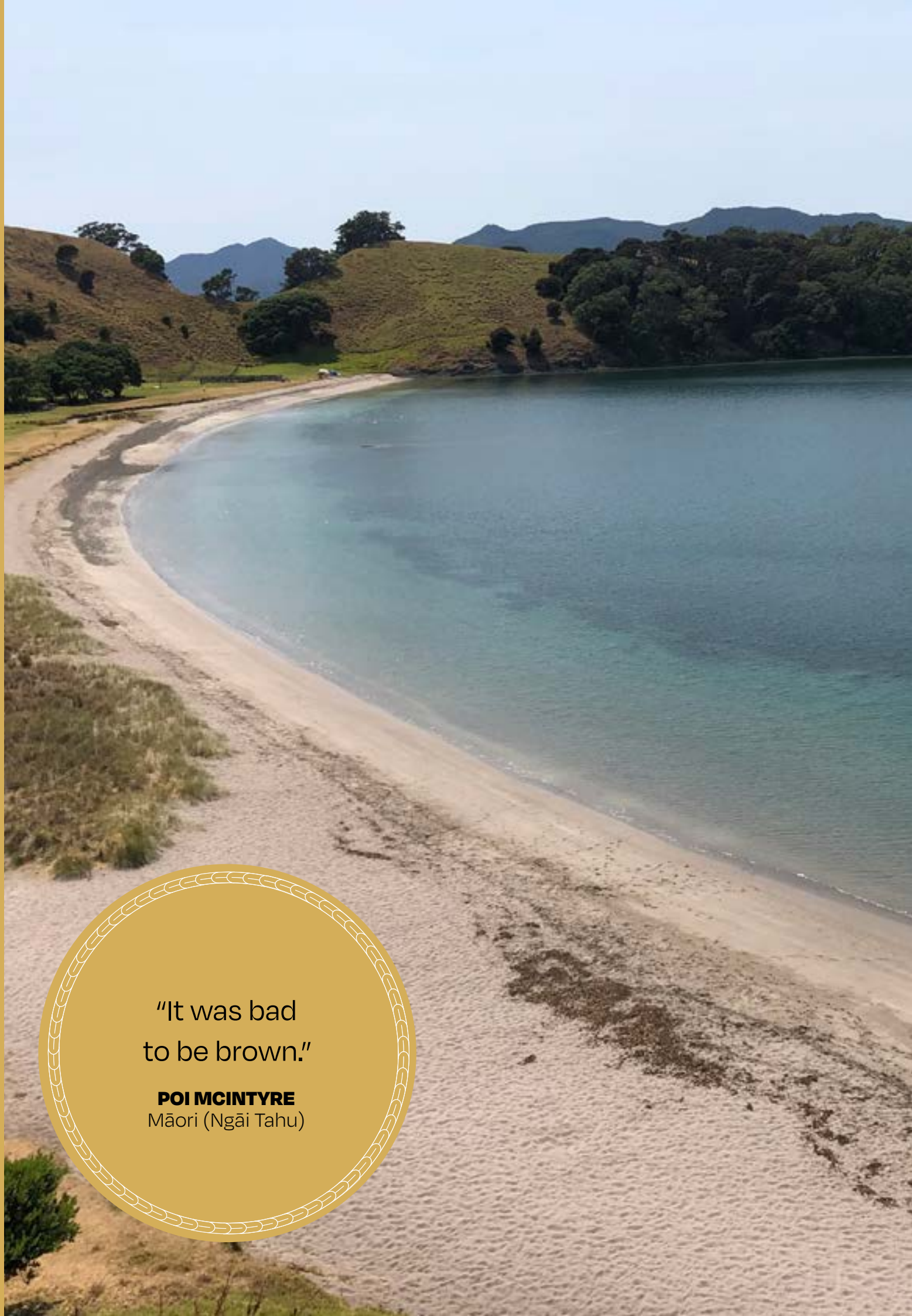
41. Te Tiriti and its principles were significantly neglected in the design, development and implementation of the care systems and this disregard of te Tiriti went to the heart of the abuse and neglect experienced by many Māori survivors and their whānau. In particular, the overlapping principles of tino rangatiratanga, kāwanatanga, partnership, active protection, options, equity, equal treatment, good government and redress were infringed as a result of the following inter-related acts or omissions:

    a) the denial of hapū and iwi mana and autonomy to care for their whānau, nourish their tamariki, rangatahi and pakeke and regulate the lives of their people
    b) the failure to address the ongoing systemic effects of colonisation
    c) the legal and practical severance of Māori survivors and their whānau from their whakapapa and their connection to their whānau, hapū and iwi
    d) the creation of care systems that:
        - excluded Māori from decision-making and influence
        - did not include or value Māori models of care
        - was embedded with racism and stripped Māori of their cultural identity
        - was hostile towards te reo Māori
    e) the failure to keep Māori safe from many forms of abuse once in care
    f) the failure to provide appropriate remedies for abuse and neglect.

42. The impact of these acts and omissions have caused significant multi-faceted harm not only to those individuals who suffered abuse in care, but an intergenerational harm to their whānau (past, present and future), hapū and iwi.

"Later, I went back to one of the boys' homes and I was put into secure and beaten again. But nothing was ever as bad as Whakapakari. I pretty much didn't fear anything after that place. For many years, I felt lots of shame and couldn't tell anyone about what had happened to me. I just walked around trying to hide what had happened."

MR PM
Pākehā



"It was bad
to be brown."

POI MCINTYRE
Māori (Ngāi Tahu)

Poi McIntyre

Age when entered care 4 years old **Year of birth** 1969

Hometown Timaru

Type of care facility Family homes – Presbyterian Children's Home, Buchanan Street Family Home, Oamaru Family Home, Woodland's Family Home; boys' homes – Dunedin Boys' Home (Lookout Point Boys' Home) in Ōtepoti Dunedin, Kohitere Boys' Training Centre in Taitoko Levin; borstal – Invercargill Borstal in Waihopai Invercargill.

Ethnicity Māori (Ngāi Tahu)

Whānau background Poi is the youngest of six siblings – he has two brothers and three sisters. Although the family had frequent interactions with the State, he was the only child to go through the 'system'.

Current Poi has two adult tamariki but does not have a meaningful relationship with either of them. He is in a committed relationship with his partner Vicki, whom he describes as his 'rock'.

I was 4 years old when I was put in a car with my siblings and cousins and told we were "going for a ride". Reading my file, Social Welfare appears to have viewed my parents as abusive and neglectful, unable to meet our basic needs.

However, my memories of my home life are wildly different. My file refers to me being left unsupervised, but there were always older siblings, cousins or whānau around. We looked out for each other. While my father used physical punishment as a form of discipline, it was never over the top. We were only ever punished for making mistakes – you knew exactly what you did wrong and why you were getting a smack. At the time, it was common parenting practice, not abuse. My file also references my parents' alcohol use, but while I do recall my parents drinking, I don't recall them drinking to excess or more than other children's parents.

My memories are of aroha, safety and abundance. My parents had a good relationship. I had a meaningful connection with Māoritanga and was part of a large and connected whānau. Although my dad was at sea a lot, my aunty and cousins lived close by, and we shared meals and resources and were always together.

Only a handful of Māori families lived in Timaru in the 1970s. Looking back, it felt like we were always trying to squash the fact we were Māori and tried to appear as white as possible to anyone outside our whānau. It was bad to be brown.

The people making decisions were Pākehā and they viewed our home life through a Pākehā lens. It was a time when Māori culture was squashed by society and practices such as tangi were not understood by Social Welfare. My whānau was judged based on this lack of understanding.

We were well-known to and targeted by government agencies in the area. We were perfect scapegoats for social ills, and easy targets. I was often targeted by police and regularly took the rap for offending that I didn't do. I believe I was accused of stealing and physically punished, often because of the colour of my skin, and when I or my whānau complained, no one listened.

The car ride I took at 4 years old marked the start of a horrific journey through the State care system that ended in men's prison, where I arrived broken and completely soulless. I don't remember being placed anywhere that acknowledged the fact I was Māori in a positive way. I was force-fed Pākehā ways of living, Pākehā values and Pākehā beliefs.

That first placement with my siblings and cousins was in the Presbyterian Children's Home in Timaru. I remember the caregiver. She was mean and hit me with a belt, I think for wetting my bed. I felt lost and scared.

When I was 12 years old, Social Welfare placed me in a family home in Timaru. This time, my siblings and cousins were left in the care of my parents. I understand it was because I stole a bicycle and Social Welfare was granted guardianship of me.

I believe that I had other placements between the Children's Home and this placement when I was 12, however there are no records about me for some years. It appears that some of my file has been lost.

While I was in this family home the caregiver accused me of stealing her wallet. My file states I admitted to this, but I know I didn't take the wallet and I didn't admit to doing it, either. I think I got the blame because I was the only Māori child in the family home. I ran away numerous times. I ran away because I hated it there and wanted to be back with my whānau.

I ran away a lot.

I believe I was placed in the Oamaru Family Home when I was 12 years old because I kept running away from the one in Timaru. The father in Oamaru was physically abusive. When I was allowed to spend holidays with my whānau, I tried to tell them and other adults how bad the home was – there is a note in my file that I reported "bad experiences at Oamaru family home". I understand my parents also laid a complaint about how I was treated. There are no further records of this, or any evidence Social Welfare bothered to look into it.

While I was in family homes I missed birthdays, tangi and other celebrations. I also missed the limited opportunities to spend time with my dad when he was home from sea. Once, when I was 13 years old, I ran away just to see Dad before he left for sea again.

In between placements in family homes, I was sent to Lookout Point Boys' Home in Dunedin. The first time I was about 12 years old. Despite my age, I was mixed in with the older boys and often beaten up. The male staff were bullies and liked to dominate – some verbally abused me almost daily. Some staff kicked or pushed me for no reason. I was propositioned for sex by an older boy. He went on to be admitted to Lake Alice and charged with sexual offending against children. I didn't tell anyone about this incident.

While I was there a staff member decided to get the tattoos on my arm and hand removed. I was taken to the onsite medical room and they were cut out by someone with a scalpel. I assumed this person was a doctor, but I am not sure. It hurt, and I was in pain after this. I remember getting a small numbing injection but not any follow up medical treatment or pain relief after. My records say that I had 27 stitches.

I don't know why I was taken to Lookout Point or why I was kept there so long. My file states the principal thought there was no reason to keep me there. Despite this, I continued to spend time at Lookout Point until I was placed in Kohitere in Levin at age 14 years old.

The eight months at Kohitere changed me in the worst way and negatively affected the rest of my life. Kohitere smelt, looked and felt terrifying. The violence between the boys was extreme, happened almost daily and was worse than any I saw later at youth or men's prison. We were constantly on edge. To survive I had to become a bully and use violence against others. This changed me. I lost empathy and became numb to witnessing and engaging in physical violence. To me, Kohitere was a training ground for jail.

The reports on my file from my time at Kohitere state I was coping well and using my time constructively. This is not my recollection. I left with a fierce hatred for the world and the system, and no empathy or self-worth. Kohitere stole my mana.

After Kohitere, my offending went through the roof. At 15 years old, I was sentenced to youth prison in Invercargill. While serving my sentence, I experienced violence, I used violence. I also experienced physical abuse from staff. Fighting was so common and normal, and I didn't know any different.

All up, I spent about 23 years in custody. Except for when we were all young, I was the only child out of my siblings to go through the 'system'. I was also the only sibling to end up in prison and in a gang.

I regularly wonder if things would have turned out differently if Social Welfare had stayed out of my life.

I have never understood why I was taken from my whānau and have felt anger about this for as long as I can remember. It has only been as an older adult and after I exited the system that I regained my mana after decades of having this figuratively and literally beaten out of me.

I was motivated to make my experience known as I don't want other tamariki to have the same experience I did. The physical and emotional abuse I experienced while under the care of the State has negatively affected every aspect of my life as an adult, and the time I spent in prison has also affected my relationship with my tamariki.

Staff members working in child protection need to have a cultural understanding of all cultures. I strongly believe I was removed from my parents' care, not because they were bad parents, but because they were Māori.

There needs to be watchers on the watchers – no one is overseeing the decisions made by agencies tasked to keep children safe. There needs to be an independent body holding them to account when they get it wrong.[19]

19 Witness statement of Poihipi McIntyre (14 March 2023).

Ūpoko | Chapter 3
Ngā kaupapa mōtika tangata
Human rights themes

43. Part 1 sets out the Inquiry's core guiding human rights themes:

    a) dignity
    b) universality
    c) self-determination, including for Indigenous peoples
    d) equality and non-discrimination
    e) indivisibility
    f) measures of protection and assistance for certain groups
    g) protection of the cultures, religions and languages of minorities
    h) participation in decision-making
    i) dynamism and the rule of law
    j) accountability and redress.

44. The Inquiry considers each of these themes in turn.

Mana
Dignity

Ngā takahitanga nui, taumaha hoki ki te mana tangata
Widespread and serious breaches of human dignity

45. In Part 1 of this report, the Inquiry referred to dignity having at least five aspects. These included the banning of all types of inhuman treatment, humiliation, or degradation, the protection of bodily and mental integrity, and ensuring the conditions for each person's self-realisation. They also included recognition that the protection of personal dignity may require the protection of group identity and culture and does require creating the conditions to ensure that each person can have their essential needs met.

46. The abuse and neglect of children, young people and adults in care is fundamentally inconsistent with the preservation and promotion of their human dignity. All abuse and neglect is unacceptable and some of the abuse and neglect recorded in the Inquiry's findings is abhorrent. As demonstrated by reactions to the Inquiry's hearings and reports, the people of Aotearoa New Zealand have been shocked by the accounts of survivors. While the number of children, young people and adults in care abused and neglected in State and faith-based care cannot be precisely determined, the available evidence backed by survivor accounts demonstrate that thousands were harmed.[20]

47. There were widespread and serious breaches of the human dignity of people in care. The Inquiry summarises below acknowledgements and apologies by the Government and faith-based institutions in relation to abuse and neglect in care, as well as referring to criminal convictions for some perpetrators of abuse. The Inquiry also highlights, by way of example, particular types of abuse and neglect which the Inquiry considers to have breached survivors' dignity.

Ngā whakamana, whakapāha hoki mai i te Kāwanatanga me ngā pūnaha taurimaā-whakapono

Acknowledgements and apologies by State and faith-based institutions

48. The State has acknowledged that physical, emotional, and sexual abuse, and neglect, including cultural neglect, occurred in its settings. Oranga Tamariki Chief Executive (Chappie) Te Kani agreed that sexual abuse in social welfare settings should be considered as a systemic problem given the amount of abuse reported.[21] Sexual abuse occurred in most care settings and some survivors were sexually abused for many years while they were in care.

49. The Ministry of Health acknowledged that much of the treatment provided in psychiatric and psychopaedic institutions would now be considered unacceptable and would constitute abuse.[22]

50. A range of faith-based institutions apologised for the abuse committed under their care, including very serious abuse that occurred at Marylands School and the Hebron Trust in Ōtautahi Christchurch.[23]

20 MartinJenkins, Indicative estimates of the size of the cohorts and levels of abuse in State and faith-based care: 1950 to 2019 (2020, pages 8–9).
21 Transcript of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 24 August 2022, page 807).
22 Brief of evidence of Director-General of Health and Chief Executive Dr Diana Sarfati for the Ministry of Health at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 3).
23 Transcript of Brother Timothy Graham at the Marylands School (St John of God) Hearing (Royal Commission of Inquiry into Abuse in Care, 15 February 2022, page 5); Witness statement of Colonel Gerry Walker on behalf of The Salvation Army (18 September 2020, paras 2.1– 2.3).

Ngā whiu taihara mō ētahi tāngata hara
Criminal convictions for some perpetrators

51. Some perpetrators were criminally convicted for the abuse they committed, including convictions for very serious offending at institutions such as Marylands School[24] in Ōtautahi Christchurch and Dilworth School in Tāmaki Makaurau Auckland.[25]

Te haupatu me ngā taikaha nui
Physical violence, including serious violence

52. Many survivors suffered serious physical violence while in care across a range of settings, and in some settings, this violence was commonplace. For much of the Inquiry period, reasonable corporal punishment by teachers, for example, was legal. Schoolmasters were "justified in using force by way of correction towards any child or pupil under [their] care, if the force used is reasonable in the circumstances".[26]

53. Corporal punishment became unlawful in schools from 23 July 1990,[27] but it was legal for parents and guardians until 2007.[28] Before then, section 59 of the Crimes Act 1961 provided that every parent of a child and every person in the place of the parent of a child was "justified in using force by way of correction towards the child, if the force used is reasonable in the circumstances". However, specific prohibitions were in place in certain settings. For example, clause 22 of the Children and Young Persons (Residential Care) Regulations 1986 prohibited staff from using corporal punishment in settings to which the Regulations applied.[29]

54. However, the Inquiry heard of many incidents of physical violence that went beyond reasonable force, and many instances where survivors were inadequately protected against physical violence from staff and peers.

24 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, pages 38, 218, 236, 272).
25 Dilworth Independent Inquiry, An independent Inquiry into abuse at Dilworth School (2023, pages 499–500).
26 See the Crimes Act, section 59, as it was between 1 January 1962 to 22 July 1990.
27 See the Education Act 1989, section 139A (No corporal punishment in early childhood services or registered schools).
28 See the Crimes (Substituted Section 59) Amendment Act 2007.
29 See also the Children, Young Persons, and Their Families (Residential Care) Regulations 1996, clause 20.

Te whakataratahinga
Solitary confinement

55. Children, young people and adults in care were placed in solitary confinement, which the Inquiry defines as confinement for more than 22 hours in one 24-hour period without meaningful human contact, as defined in Rule 44 of the United Nations Standard Minimum Rules for the Treatment of Prisoners that were adopted in 2015. While the rules apply to adult prisoners and the definition in Rule 44 did not apply during the Inquiry period, the Inquiry considers it to be a useful definition because there does not appear to be any universally applicable definition to the care settings within scope during the Inquiry period.[30]

56. As detailed in Parts 4 and 5, the conditions in some settings in which solitary confinement occurred (including but not limited to 'secure care') were inconsistent with the need to maintain the mental integrity of those in care, and their dignity more generally. That included where people in solitary confinement rooms had no or very limited access to toilets or baths, or where the rooms were otherwise unhygienic, where people were deprived of food and water, and where the rooms were dark, cold or very hot. It also included where people had nothing to do while they were in solitary.

57. Oranga Tamariki recognised that conditions in some of the secure units in social welfare residences, particularly children's homes, were inhuman. Solitary confinement conditions in disability and mental health settings were inconsistent with the need to maintain the dignity of those in care.

58. Any person in care and in solitary confinement is highly vulnerable, and there was an obvious risk of abuse occurring in solitary confinement. Multiple survivors suffered serious abuse while they were in solitary confinement, including rape by staff and peers. Protections against abuse by staff and peers for those in solitary confinement, to the extent there were any, were inadequate.

30 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), rule 44 (General Assembly resolution 70/175, annex, adopted on 17 December 2015). See also Shalev, S, Uses and abuses of solitary confinement of children in State-run institutions (2022, page 4).

59. Some survivors were subjected to lengthy periods of solitary confinement.[31] Where those periods of solitary confinement were imposed as punishment, they were inconsistent with human dignity. This was particularly so when the conditions in solitary confinement were poor, and where children, young people and adults in care subject to it were deprived of access to education or other activities. Even taking into account differing understandings about solitary confinement over the Inquiry period, those in charge should have understood that putting them in solitary confinement for long periods as a disciplinary measure was wrong (note that the Residential Social Workers Manual 1975 referred to the possibility of using "secure facilities as punishment" in "certain cases of absconding or serious and persistent misbehaviour").[32]

60. From 1986 confinement of any duration for the purposes of punishment in children's residences was not permitted.[33] From December 1990, solitary confinement as a disciplinary measure for detained children and young people under 18 years of age breached the United Nations Rules for the Protection of Juveniles Deprived of their Liberty.[34]

61. The routine use of solitary confinement on arrival in some settings, such as Epuni Boys' Home in Te Awa Kairangi ki Tai Lower Hutt, Kingslea Girls' Home in Ōtautahi Christchurch and Ōwairaka Boys' Home in Tāmaki Makaurau Auckland was inconsistent with their dignity. It also breached the Residential Social Workers Manual 1975, which stated that secure facilities could be used directly on admission where "elements of an emergency or disturbance or difficult behaviour" were involved, but that "[u]nder no circumstances is it an acceptable procedure for all new admissions to be admitted direct to secure facilities,"[35] and was apparently inconsistent with the regulatory framework in place subsequently for residences.[36]

62. While solitary confinement might have been occasionally justified by health and safety reasons or the risk of running away, it should only have occurred after all reasonable alternatives had been considered. Once imposed, everything possible should have been done to ensure that any period of confinement remained limited, and that the conditions of detention should have been consistent with human dignity.

31 See Royal Commission in Inquiry into Abuse in Care, Final report, Part 5: Impacts (2024, paras 329, 331).
32 See Department of Social Welfare, Residential Social Workers Manual (1975, section F6.09) in Shalev, S, Uses and abuses of solitary confinement of children in State-run institutions in Aotearoa New Zealand (2022, pages 11–12).
33 See the purposes children and young persons in residences could be placed in secure care for, as set out in, for example, in the Children and Young Persons (Residential Care) Regulations 1986, regulation 28, and the Children, Young Persons, and Their Families Act 1989, section 368 (as it then was). Punishment is not one of these purposes.
34 United Nations Rules for the Protection of Juveniles Deprived of their Liberty, Rule 67 (4 December 1990), General Assembly resolution 45/113.
35 See Shalev, S, Uses and abuses of solitary confinement of children in State-run institutions in Aotearoa New Zealand (July 2022, pages 11–12).
36 See the Children and Young Persons (Residential Care) Regulations 1986, regulation 28, and the Children, Young Persons, and Their Families Act 1989, section 368.

Ngā matea tika kāore i tutuki
Essential needs not met

63. Conditions in some care settings did not meet appropriate minimums, even taking into account differing care standards that may have applied in the past. The Inquiry heard multiple accounts of children, young people and adults in care not having appropriate access to healthcare and not otherwise having their essential needs met. This included survivors who were at Whakapakari on Aotea Great Barrier Island living in tents for up to six months, hungry, cold and without access to basic health care or basic hygiene. It also included disabled survivors not being properly cared for, including in relation to basic hygiene, nutrition and dental care.

He mātauranga takarepa, kore mātauranga rānei
Inadequate or no education

64. Many survivors left care without an adequate education and an understanding that they were a deserving member of society. This compounded the disadvantage caused by abuse and other forms of neglect in care.

65. Some survivors received no or only a limited education while they were in care. These included disabled survivors in care for very long periods at institutions such as the Templeton Centre, near Ōtautahi Christchurch, and Kimberley Centre, in Taitoko Levin, some survivors of special residential schools, and survivors of institutions that cared for children and young people such as Hokio Beach School, located near Taitoko Levin, Kohitere Boys' Training Centre, in Taitoko Levin, and Whakapakari, on Aotea Great Barrier Island. Some survivors who were in solitary confinement received no education during those periods, some of which were extended; the focus was on manual work rather than education.

Te whakamania, te ūnga me ētahi atu momo
Verbal and other abuse, and targeted abuse

66. Survivors were often subjected to verbal and other psychological abuse and this was highly destructive, particularly when survivors were regularly denigrated by the people who were supposed to be caring from them, or when carers allowed or encouraged the abuse of survivors by others. Survivors were also subjected in some cases to highly abusive treatment such as being made to eat outside and to sleep outside with animals. In some cases, such as at Marylands School in Ōtautahi Christchurch, particularly vulnerable children including disabled children were targeted for abuse.

Tukupū
Universality

67. People in care should have had their fundamental human rights observed and Aotearoa New Zealand should have had in place effective mechanisms to ensure those rights were respected, protected and fulfilled. These mechanisms were either not in place or were inadequate.

Tino rangatiratanga
Māori self-determination

68. Māori were disproportionately represented in care. The care provided to tamariki Māori, rangatahi Māori and pakeke in care was largely determined by Pākehā authorities rather than Māori authorities. It has largely been for Pākehā rather than Māori authorities to decide whether or not abuse has occurred, if so, what the responses to that abuse should be, and what should be done to prevent further abuse.

69. The Government prevented Māori from assuming their role in caring for tamariki, rangatahi and pakeke Māori. The State has acknowledged that Māori solutions and perspectives have historically been ignored across the care and protection system (that is, the system providing care for children and young people who came under relevant child welfare law).[37]

70. Respect for te Tiriti o Waitangi rights including tino rangatiratanga, and Māori self-determination rights, requires a different approach. The Inquiry sets out what that approach should be in its Inquiry recommendations.

Te manarite me te kore whakatoihara
Equality and non-discrimination

71. Tamariki, rangatahi and pakeke Māori and Pacific children, young people and adults in care experienced racial abuse while they were in care as well as incidents of differential treatment because of their colour or ethnicity. The State has accepted in social welfare settings that "structural racism is a feature of the care and protection system which has had adverse effects for tamariki Māori, whānau, hapū and iwi".[38]

37 Brief of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 9 August 2022, para 38), recording one of the concessions made on behalf of the Crown at the Waitangi Tribunal urgent Inquiry (Wai 2915) in November 2020.

38 Brief of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 9 August 2022, pages 5–6, para 35).

72. Deaf and disabled people also experienced verbal abuse related to being Deaf or disabled. Lack of accessibility to information, communication assistance and oralism contributed to abuse and neglect. Many were not allowed to live independently and were not included in their local communities. Disabled people in care were not generally seen as having equal rights to other members of the community. The care they received, including their education, was negatively affected, in some cases significantly so, by discrimination. The lack of recognition of disabled peoples' rights resulted in an absence of the support and accommodations needed.

73. These points are discussed further in the case studies into the Kimberley Centre and Van Asch College and Kelston School for the Deaf.

Wāhikore
Indivisibility

74. This principle refers to the need for civil and political rights (that is, the right not to be subjected to degrading treatment or punishment and the right to security of the person) and economic, social and cultural rights (that is, the right to education and the right to take part in cultural life) to be equally protected. Both sets of rights were insufficiently protected.

Ngā whakaritenga tiaki, āwhina hoki
Measures of protection and assistance

75. For a long time, Aotearoa New Zealand has recognised that children and young people are vulnerable and require special protection and assistance. The same applies to Deaf and disabled people, and people experiencing mental distress. Aotearoa New Zealand has also recognised the importance of the family, and the need to protect the family.

76. Despite this, the Inquiry heard of numerous cases where children, young people and Deaf and disabled people, and people experiencing mental distress, were abused and neglected in care. Rather than having a heightened level of protection as their status required, they were insufficiently protected.

77. Also, while some children and young people could not always remain with their whānau, Parts 4 and 5 discuss survivor accounts where whānau, hapū and iwi connections were unnecessarily limited or severed entirely. At the Inquiry's State Institutional Response Hearing, Oranga Tamariki Chief Executive Chappie Te Kani stated:

> *"I acknowledge that the care and protection system between 1950 and 1999 did not have the legislative or policy settings to ensure sufficient emphasis was put on considering alternatives before placing children in State care. This included not always providing support to families in need and not always working with extended family, whānau, hapū and iwi to support them to care for their tamariki safely and choosing to place some tamariki with non-kin caregivers rather than exploring family options."*[39]

78. Wherever possible, these and other family connections should have been maintained. This includes not only connections between survivors and their parents but also survivors and their siblings.

79. Some mothers were 'forced' into offering their children for adoption, leading to life-long suffering. These adoptions were contrary to the mother's dignity and the need to protect the family. They were also inconsistent with the right of the child adopted to, where possible, grow up under their parent's care and responsibility.[40]

39 Brief of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 9 August 2022, para 42).
40 See Principle 6, United Nations Declaration of the Rights of the Child, GA Res 1386 (XIV) (1959, page 19).

Te tiaki i ngā ahurea, ngā whakapono me ngā reo o te tokoiti
Protection of the cultures, religions and languages of minorities

80. Care was largely monocultural during most of the Inquiry's reporting period. Rather than being protected, te reo, tikanga and mātauranga Māori were prohibited in some settings. Other aspects of Māori culture were suppressed. While there were exceptions to this approach, such as Māori faith-based boarding schools, there was little to no access to Māori culture or mātauranga Māori in care settings.

81. There was generally no importance placed on the cultures or languages of Pacific Peoples. Pacific survivors who were not told while they were in care that they had Pacific heritage or who did not have that heritage recorded and later discovered it, felt that they had lost a part of themselves.

82. Deaf people who attended residential special schools were prohibited from using Sign Language.[41] At the Inquiry's State Institutional Response Hearing, Oranga Tamariki Chief Executive Chappie Te Kani acknowledged that many Deaf children "were denied their language and their place in their community".[42]

83. Often ethnicity was not recorded at all or recording practices were poor. Without knowing the ethnicity of a person in care, it is difficult to see how any steps could have been taken to protect that individual's culture or language.

Te whai wāhi ki ngā whakatau
Participation in decision making

84. Attitudes and understandings both in Aotearoa New Zealand and internationally about the rights of people in care to participate in decisions affecting them changed during the Inquiry period and the nature and extent of participatory rights now are significantly different.

85. The Inquiry demonstrates the importance of people in care having their right to autonomy respected and having strong rights to participate in decisions affecting them. These include the right to information relevant to those decisions and otherwise to give informed consent, and the right to support where required so that people can make their own decisions.

86. Collective organisations of people directly affected by care systems, such as hapū, iwi or disabled people's organisations, did not consistently have input into system design and implementation. Collective participation in decision making on care needs to be ensured.

41 Brief of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 9 August 2022, paras 44–46); See also Royal Commission into Abuse in Care, Our hands were tied, Settings case study: Van Asch College and Kelston School for the Deaf (2024).

42 Brief of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 9 August 2022, para 46).

Te uekaha me te mana o te ture
Dynamism and the rule of law

87. The scope, nature and content of human rights changed during the Inquiry period. Formal legal protections for human rights increased. This included ratification by Aotearoa New Zealand of a range of international treaties starting in the 1970s, and the enactment of the New Zealand Bill of Rights Act in 1990 and the Human Rights Act in 1993.

88. Those developments should have led to increased protection for the human rights of those in care, including an increasing focus on human rights standards in care. While there were improvements in some areas, human rights protections for those in care were inadequate.

I mua i te 1990
Before 1990

89. Before the New Zealand Bill of Rights Act 1990, and despite Aotearoa New Zealand having ratified a number of international human rights treaties, there was little visibility of human rights in relation to care settings. Also, while there seemed to be an understanding in some circles that before 1990 these rights were protected by the common law and by practice in Aotearoa New Zealand,[43] that understanding is not supported by many survivors' accounts. The extensive and very serious abuses at, for example, the Child and Adolescent Unit at Lake Alice Hospital in Rangitikei and Marylands School in Ōtautahi Christchurch, demonstrate to that before 1990 the human rights of those in care were not sufficiently protected by law, or otherwise.

Whai muri i te 1990
After 1990

90. The enactment of the New Zealand Bill of Rights Act brought a greater level of legal protection for human rights generally. The Inquiry saw little evidence, however, that there were greater levels of protection in the context of care. Serious abuse and neglect occurred at Hebron Trust in Ōtautahi Christchurch and Whakapakari on Aotea Great Barrier Island after 1990. Also, the Inquiry's interim report He Purapura Ora, he Māra Tipu includes a finding that State agencies did not consider survivors' human rights when designing the State claims processes for abuse in care.[44]

43 See the discussion in Palmer, G, "A Bill of Rights for New Zealand: A White Paper" Appendix to the Journals of the House of Representatives, Volume 1 A6 (1985, paras 4.27–4.28).
44 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui, Volume 1 (2021, page 158).

91. Obstacles such as the accident compensation bar,[45] limitation periods,[46] and the generally limited amounts ordered by the courts to date as Bill of Rights compensation are strong disincentives to accessing the courts in relation to abuse and neglect in care. Dr R Harrison KC has argued that the sums awarded as Bill of Rights compensation by the Supreme Court in Taunoa v Attorney-General [2007] "are so small as to be derisory", and "the narrow and niggardly approach adopted by the majority Judges in Taunoa both devalues human rights and at the same time disincentivises litigation seeking to enforce them".[47] An exception to this is Fitzgerald v Attorney-General [2022]. The Inquiry understands, however, that the Crown appealed this judgment to the Court of Appeal, the appeal has been heard, and judgment is awaited.

92. Also, some of the rights in international treaties to which Aotearoa New Zealand is a State party are not in the Bill of Rights Act, including a general right to security of the person.[48] Actions based on those rights cannot therefore be brought to the courts here.[49]

Te papanga, me te mōtika ki tētahi tūhura wawe, tōkeke hoki, me te whai hua

Accountability, including the right to a prompt and impartial investigation and to an effective remedy

93. Accountability for abuse in care has been the exception rather than the norm. There was a lack of clear and accessible complaints processes in many settings, and little accountability where standards of care were breached, as acknowledged by Oranga Tamariki Chief Executive Chappie Te Kani at the Inquiry's State Institutional Response Hearing in relation to the care and protection system.[50] Many survivors have not received fair compensation, rehabilitation and redress.

94. In He Purapura Ora, he Māra Tipu the Inquiry found that many obstacles in the legal system exist for survivors seeking redress, and the Inquiry made recommendations to address these. Survivors are still waiting to see whether the State will accept those recommendations.

45 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui, Volume 1 (2021, page 331).
46 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui, Volume 1 (2021, page 335).
47 Taunoa v Attorney-General [2007] NZSC 70, [2008] 1 NZLR 429; Harrison, R, Remedies for breach of the New Zealand Bill of Rights Act 1990: The New Zealand experience – Recognising rights while withholding meaningful remedies, paper presented to the New Zealand Law Society Using Human Rights Law in Litigation Intensive Conference (June 2014, pages 13–14); Fitzgerald v Attorney-General [2022] NZHC 2465; [2023] 2 NZLR 214.
48 Butler, A & Butler, P, The New Zealand Bill of Rights Act: A Commentary (2nd edition, LexisNexis, 2015, para 35.6.16).
49 For further analysis, see Butler, A & Butler, P, The New Zealand Bill of Rights Act: A Commentary (2nd edition, LexisNexis, 2015, paras 35.6.14–35.6.21).
50 Brief of evidence of Chief Executive Chappie Te Kani for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 9 August 2022, para 41).

95. When this Inquiry began, survivors generally did not have good options for seeking redress. There was infrequent criminal prosecution of perpetrators.[51] Survivors were largely prevented from accessing the courts. The Accident Compensation Corporation did little for most of them. The State and some faith-based institutions provided a range of largely informal out-of-court processes. However, as the Inquiry found in its report He Purapura Ora, he Māra Tipu, these were generally inconsistent, inadequate, inaccessible for many people, and otherwise unsatisfactory.[52]

96. So, and for example, a person who had been raped when they were in care as a child now seeking redress would face many significant obstacles. The only real option would be a low-level, out-of-court settlement, and the terms would be substantially controlled by the institution where the abuse occurred.[53]

97. For many survivors, the obstacles and other issues referred to above remain. This is inconsistent with basic understandings of justice and fairness, and with the values Aotearoa New Zealand purports to hold. Significant change is required before it can be said that Aotearoa New Zealand is meeting its human rights obligations to survivors of abuse in care.

51 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui, Volume 1 (2021, page 242).
52 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui, Volume 1 (2021, pages 150–205, 210–211, 228–248, 305–306, 330–333, 335–338).
53 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From redress to Puretumu Torowhānui, Volume 1 (2021, pages 151–156).

"His body still carries the scars."

GAY ROWE
(Paul's sister)

Paul Beale

Hometown Heretaunga Hastings	**Age when entered care** 10 years old
Year of birth 1951	**Time in care** 1961– 2012
Type of care facility Hospital – the Kimberley Centre in Taitoko Levin; residential home – Parklands in Ōtautahi Christchurch.	
Whānau background Paul has a sister, Gay, who is now his welfare guardian.	
Current Paul lives at a residential whānau home, where he enjoys a range of activities and a good quality of life.	

⚠ My brother Paul was diagnosed with an intellectual disability at 2 ½ years old. I'm his sister and welfare guardian. He functions intellectually at a very basic level and his vocabulary and decision-making are quite limited. He has little awareness of physical danger.

After attending the local IHC Fairhaven School, it was suggested that Paul attend Kimberley Hospital where he would receive an education. At 10 years old, Paul was taken to Kimberley, where he spent more than 40 years. As a child, I would sometimes visit with my parents and, during school holidays, Paul would come home to Hastings.

When we visited Paul, he was in a ward with what seemed like about 50 others but could have been as few as 30. They were all males and they slept in dormitory-type accommodation.

At mealtimes, others around Paul would grab his food if it was not eaten quickly. The assistants stood around watching. Later, Paul was diagnosed as a 'choker' because he just swallowed his food so no-one else could get it.

Each time he came home, he had a new scar somewhere on his body. We were told this was from 'fighting'. There were fights going on all the time at Kimberley and the attendants only stepped in when they were not going to get injured. His body still carries the scars from there.

Sometimes the residents were very roughly handled by the attendants. I pleaded for my parents to take Paul out of there. After getting married, I even offered to look after him in my own home. Sadly, my pleas fell on deaf ears.

As an adult, I would take Paul out to lunch and then to the park where he could go on the swings. On one visit, I noticed a young man sitting on a chair with restraints on his wrists and legs. I was shocked and when I asked why, I was told he was a runner. This didn't make sense to me as the door to the outside yard was locked anyway. There were about a dozen young men in there with special needs, and only two assistants to look after them.

As Paul got older, he was moved from one ward to another, supposedly to be with like folk. He was given drugs that made him like a zombie – he just sat and only spoke when spoken to. I suspect the drugs were given to the residents to keep them quiet.

One of the side effects of the medication was dribbling. In 2002 or 2003, I collected Paul to take him to my home in Onewhero for a week. He was drugged up so much, we had to change his t-shirt at least eight times a day to prevent him from being wet all the time. After that, I asked if the meds that were causing him to dribble and his neck muscles to atrophy could be replaced with something that was a bit kinder to his body.

My parents had been told that he needed them because he had seizures. However, Paul had witnessed another resident having seizures and then getting a lot of attention and care, so he began to lie on the ground and shake. Those around him thought he was suffering a seizure. I have only witnessed him having a true seizure once while at home on holiday, and he has not had a seizure since leaving Kimberley.

Paul moved to Parklands in May 2005 and stayed there until September 2012.

His welfare was entrusted to me by our late parents and I have always done my best to look out for his interests and to ensure he is treated with appropriate care. After having a look around, Parklands appeared to be everything we wanted, and Paul liked it too, which was very important to me.

Everything went well at Parklands for the first 18 months or so, but after that the cracks began to show. Paul had a terrible time.

We were told that Parklands was supposed to be getting most of his benefit to go towards his cost of living. I was very unhappy about this because, in my view, the money the proprietors were already getting for Paul, which was significant, was sufficient.

The proprietors didn't properly account to me for monthly expenditure, and it seemed quite expensive – so I started to ask questions. Paul was not adequately fed, and his account would be charged for food purchased on day trips. I became aware towards the end of Paul's time at Parklands that his diet was bland and monotonous.

Poor attention was paid to Paul's personal hygiene. He wet the bed virtually every night – the response was to remove his mattress, so that he had to sleep on a thin, plastic-covered foam squab, much like a hospital one. There were no springs or support for Paul who had had a hip joint replacement.

When I asked what had happened to Paul's regular mattress, I was told he had wet it so much it stank, and staff had taken it down to the paddock and burned it. There was no consultation about this.

I found this particularly frustrating because I had provided Parklands with mattress protectors for this reason. As Paul doesn't have the capacity to look after his teeth properly, I also sent a battery-run toothbrush to Parklands, which wasn't used.

On more than one occasion the owners' dogs urinated and defecated on the carpet in Paul's room so the carpet was removed. Residents were also made to pick up dog faeces from the yard each morning.

The owners shouted at residents, and removed personal items to punish them, despite the fact that they were all people with disabilities. A staff member squirted Paul with water whenever he was perceived to be becoming loud or aggressive. This was deliberate exploitation of a very genuine fear Paul has of water.

Paul was also assaulted at Parklands, both by staff and other residents. He started to have unexplained injuries, despite not having a history of clumsiness. Staff told me 'off the record' that Paul's injuries were the result of him being regularly assaulted by other residents.

In April 2006, Paul's medical records show that he presented at the local medical clinic with a fracture. The next month, he had severe bruising on his left upper arm. In October 2006, he fell over and hurt his shoulder. Another record of that incident stated that Paul had 'somehow' managed to sustain the injury. Much later, I saw handwritten notes recording that Paul had been kicked and punched by other residents, but no incident reports had been prepared.

In March 2008, Paul was assaulted by another resident, resulting in a head injury. The ambulance officer confirmed that Paul had a bleeding head and ear, and scratching and bruising to his right arm. The next day, I took Paul to my doctor to get him checked over thoroughly. They observed that the arm injury was on top of another injury we had not been informed about.

About a month later, Paul complained to a staff member that his right leg was sore, and he seemed to be limping. Three days later, another staff member phoned to say that his foot was sore, red and swollen. His foot was x-rayed and displayed fractures. I was told by a nurse that this type of injury was likely to have come from somebody standing on Paul's foot. When I told two staff members at Parklands, they said Paul had been assaulted by another resident while he was in his bedroom.

I was informed that, as a result of this, Paul was, in addition to being sedated, now locked in his room at night. This was a safety concern given the number of evening staff rostered on. I was also very unhappy about how Paul's medication was managed. As Paul's welfare guardian, I was supposed to approve any sedative medication. However, he was routinely sedated without my consent.

In April 2009, Paul was at the medical centre again. This time, the records stated that he fell in the bath and bashed his forehead. He presented twice at the medical centre in 2010. On the first occasion, his records stated that he slipped on a step and grazed his lower leg, which became infected. The second time, he was described as having an infection from a scratched arm.

In May 2010, another record described Paul as having an "unwitnessed fall", which again resulted in a fracture. In October 2010, he was scratched on the head by another resident and, in 2011, an incident report stated that he had been bitten on the cheek by another resident. On one occasion, I took Paul to hospital. His shirt was lifted and he had a massive bruise on the side of his ribs, which nobody was able to explain.

I continually tried to take steps to protect Paul and to stand up for his rights. In 2006, I contacted the police about a staff member who had assaulted Paul. This eventuated in a court case. The staff member was charged with assault and she was asked to leave Parklands.

In making a legal claim against the Ministry of Health for the abuse and neglect suffered by Paul, it also came to light that he had been sexually assaulted by two Parklands staff members.

I regularly voiced my concerns regarding the poor quality of residential care and requested the opportunity to explore alternative options for Paul. In April 2008, attempts finally began to be made to find an alternative placement for Paul. However, he remained at Parklands until late 2012.

Paul was moved and continues to reside at a residential whānau home. From there he attends activities, including going on twice weekly walks, movie visits, one-on-one walks and attending whare lunches and picnics. His quality of life is significantly better than it was at Parklands.[54]

54 Affidavit of Gay Rowe (12 February 2020).

Ūpoko | Chapter 4
Ngā kitenga matua
Key observations

98. Under the terms of reference the Inquiry must make general comments, findings, or both, about the nature and extent of abuse and neglect that occurred in State and faith-based care during the Inquiry period.[55]

Ngā taunakitanga mō ngā takahitanga maha o te Tiriti me ōna mātāpono
Strong evidence of numerous breaches of te Tiriti and its principles

99. The terms of reference directed the Inquiry to apply te Tiriti and it principles to its work.

100. The findings in Parts 3 to 5 provide strong evidence that there have been numerous infringements of te Tiriti o Waitangi principles that apply in relation to the care of tamariki Māori, rangatahi Māori and pakeke Māori across multiple settings. There is strong evidence that te Tiriti o Waitangi and its principles were not taken into account in many care settings, to the significant detriment of tamariki Māori, rangatahi Māori and pakeke Māori in care, and this had a significant inter-related impact on whānau, hapū and iwi, and caused intergenerational harm. The Inquiry is profoundly concerned about this conclusion.

Ngā taunakitanga mō ngā takahitanga maha o ngā mōtika tangata i ngā tautuhinga maha
Strong evidence of numerous human rights violations across multiple settings

101. In Part 1, the Inquiry set out a range of non-binding human rights declarations relevant to care which Aotearoa New Zealand supported before and during the Inquiry period, and the legally binding human rights treaties Aotearoa New Zealand chose to join.

55 Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018, clauses 10.1 and 31(a).

102. The findings in earlier Parts of this report provide strong evidence that the fundamental human rights of people in care were breached in multiple settings. There is strong evidence that many of the civil, political, economic, social and cultural rights referred to in human rights declarations and treaties were not upheld in many settings, to the significant detriment of those in those settings. The Inquiry is profoundly concerned by this conclusion.

Ngā take kino rawa o te tūkino me te whakahapa
Very serious cases of abuse and neglect

103. The Inquiry's report Beautiful Children, on the Lake Alice Child and Adolescent Unit, sets out how the use of electric shocks and paraldehyde as punishment met the definition of torture as outlined by Aotearoa New Zealand's Solicitor-General, Ms Una Jagose. The State has not disputed these findings.

104. These cases also include the pervasive and severe sexual abuse and neglect of children and young people that occurred at Marylands School in Ōtautahi Christchurch, between approximately 1955 and 1983 and at Hebron Trust in Ōtautahi Christchurch between approximately 1986 and 1992. The report Stolen Lives, Marked Souls discusses evidence that some of the St John of God Brothers used sexual abuse to punish children and young people or to intimidate them, or combined sexual abuse with other acts of punishment.[56]

105. The case studies into the Kimberley Centre in Taitoko Levin and Whakapakari on Aotea Great Barrier Island include evidence of sexual and other abuse being used to punish children and young people or to intimidate them. One of the elements of torture is severe pain or suffering, whether physical or mental, and the Inquiry recorded that sexual offending may constitute torture. This includes rape, which has been recognised as torture where at least one of the purposes for the rape was a prohibited purpose (to punish, to intimidate or coerce, or for a discriminatory purpose), and where the rape was committed by or with the consent or acquiescence of a person acting in an official capacity.[57]

56 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, pages 44, 165, 166, 194, 195).
57 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, page 303).

106. In a 1986 report,[58] a United Nations Special Rapporteur set out examples of acts he considered would amount to physical and psychological or mental torture where they caused severe physical or mental pain or suffering, were intentionally inflicted for a prohibited purpose, and for which a person acting officially was responsible.[59] These examples included beatings that cause wounds, internal bleeding, fractures or cranial traumatism, burns including cigarette burns, electric shocks causing intensive muscular contractions, suffocation by near-drowning in water, rape, and the insertion of objects into body orifices. The Special Rapporteur also referred to the administration of certain drugs in detention or psychiatric institutions (including neuroleptics), that caused trembling, shivering and contractions, but "mainly make the subject apathetic and dull his intelligence,"[60] the prolonged denial of food, the prolonged denial of sufficient hygiene, the prolonged denial of medical assistance, total isolation and sensory deprivation, threats to kill or torture relatives, total abandonment, and simulated executions as possible acts of torture.

107. Other forms of sexual abuse, and sufficiently serious corporal punishment, can constitute cruel, inhuman or degrading treatment or punishment. The cumulative impact of conditions over time can also result in treatment being cruel, inhuman or degrading or otherwise contrary to human rights.[61] As set out in Stolen Lives, Marked Souls, Aotearoa New Zealand likely has a positive obligation to take effective measures designed to ensure that individuals within its jurisdiction are not subjected to torture or cruel, inhuman or degrading treatment or punishment, including such ill-treatment by private individuals.[62]

108. Numerous cases of sexual abuse occurred in most care settings. A significant amount of sexual abuse would cause severe physical or mental pain and suffering, including penetrative and repetitive sexual abuse.

109. Survivors gave testimony of cigarettes being put out on them or otherwise being burnt with cigarettes. The Inquiry has recorded many cases of severe physical abuse. There are many other accounts of survivors experiencing severe pain and suffering due to abuse at the hands of those responsible for their care, including Government staff and people approved by the Government to provide care.

58 Kooijmans, P, Torture and other cruel, inhuman or degrading treatment or punishment – Report by the Special Rapporteur, Mr P Kooijmans, appointed pursuant to Commission on Human Rights resolution 1985/33 (United Nations Economic and Social Council, 1986).

59 48 Kooijmans, P, Torture and other cruel, inhuman or degrading treatment or punishment – Report by the Special Rapporteur, Mr P Kooijmans, appointed pursuant to Commission on Human Rights resolution 1985/33 (United Nations Economic and Social Council, 1986, paras 32–38).

60 Kooijmans, P, Torture and other cruel, inhuman or degrading treatment or punishment – Report by the Special Rapporteur, Mr P Kooijmans, appointed pursuant to Commission on Human Rights resolution 1985/33 (United Nations Economic and Social Council, 1986, page 29).

61 Taunoa v Attorney-General [2007] NZSC 70, [2008] 1 NZLR 429 (paras 6, 69 and 94 per Elias CJ, para 153 per Blanchard J, para 283 per Tipping J, and para 362 per McGrath J).

62 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, pages 304–305).

110. All of these matters give rise to a blatant and egregious disregard of the human rights of those individuals placed there including very serious issues of torture, and of cruel, inhuman or degrading treatment or punishment.

Te Whakapakari Youth Programme ki Aotea
Te Whakapakari Youth Programme on Aotea Great Barrier Island

111. As discussed in the Te Whakapakari Youth Programme (Whakapakari) case study, survivors were subjected to severe pain and suffering by people working for Te Whakapakari Youth Trust, a provider of child and family support services approved by the government in terms of section 396 of the Children, Young Persons, and Their Families Act 1989. This abuse included the rape of survivors and severe physical beatings by staff or by other children apparently with the acquiescence or encouragement of staff. It also included threats to kill survivors and threats against a survivor's mother and family if the survivor said anything negative about Whakapakari. There was evidence of survivors being bitten by dogs and being forced into a dog kennel, having shots fired over their heads or towards them, and of a mock execution involving survivors being forced to dig their own graves at gunpoint and get into them. A survivor gave evidence that a staff member held another young person under the water in a creek. There is also evidence that the purposes of that abuse included the intimidation, punishment, and coercion of survivors. Very serious issues of torture, and of cruel, inhuman or degrading treatment or punishment, therefore arise

112. Serious issues of torture, and of cruel, inhuman or degrading treatment or punishment, also arose in relation to Whakapakari staff sending survivors on their own to Whangara Island, known as 'Alcatraz', apparently as a form of punishment. This was an extreme form of solitary confinement constituting serious abuse, including because it involved the abandonment of the survivors on Whangara Island. Issues of degrading treatment also arise in relation to the routine strip-searching of survivors on arrival. Multiple complaints were made to authorities about Whakapakari and these were not appropriately addressed.

113. Survivors who were at Whakapakari after 4 December 1990 and who were under 18 years of age should be considered as having been deprived of their liberty under the United Nations Rules for the Protection of Juveniles Deprived of their Liberty.[63] This refers to "any form of detention or imprisonment or the placement of a person in a public or private custodial setting, from which this person is not permitted to leave at will, by order of any judicial, administrative or other public authority". The "Rules apply to all types and forms of detention facilities in which juveniles are deprived of their liberty. Sections I, II, IV and V of the Rules apply to all detention facilities and institutional settings in which juveniles are detained, and section III applies specifically to juveniles under arrest or awaiting trial."

114. The Inquiry finds that the practices at Whakapakari as detailed in the case study constitute serious and extensive breaches of the United Nations Rules, including:

- Rule 12 (deprivation of liberty should only occur in conditions and circumstances which ensure respect for juveniles' human rights)
- Rule 28 (the detention of juveniles should only take place under conditions that take full account of their particular needs, status and special requirements, and which ensure their protection from harmful influences and risk situations)
- Rule 31 (juveniles deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity)
- Rule 33 (sleeping accommodation should normally consist of small group dormitories or individual bedrooms, and every juvenile should be provided with separate, clean and sufficient bedding)
- Rule 36 (every detention facility shall ensure that each juvenile has personal clothing suitable for the climate and adequate to ensure good health)
- Rule 37 (every detention facility shall ensure that every juvenile receives food that is suitably prepared and presented at normal meal times and of a quality and quantity to satisfy the standards of dietetics, hygiene and health)
- Rule 38 (every juvenile of compulsory school age has the right to education suited to his or her needs and abilities and designed to prepare him or her for return to society. Such education should be provided outside the detention facility in community schools wherever possible. Juveniles who are illiterate or who have cognitive or learning difficulties should have the right to special education)

63 United Nations Rules for the Protection of Juveniles Deprived of their Liberty, rules 11(b), 15, (4 December 1990), General Assembly resolution 45/113.

- Rule 41 (every detention facility should provide access to a library that is adequately stocked with both instructional and recreational books and periodicals suitable for the juveniles, who should be encouraged and enabled to make full use of it)
- Rule 42 (every juvenile should have the right to receive vocational training in occupations likely to prepare him or her for future employment)
- Rule 49 (every juvenile shall receive adequate medical care, both preventative and remedial)
- Rule 51 (every detention facility for juveniles should have immediate access to adequate medical facilities and equipment appropriate to the number and requirements of its residents and staff trained in preventive health care and the handling of medical emergencies. Every juvenile who is ill, who complains of illness or who demonstrates symptoms or physical or mental difficulties, should be examined promptly by a medical officer)
- Rule 59 (every means should be provided to ensure that juveniles have adequate communication with the outside world)
- Rule 60 (every juvenile should have the right to receive regular and frequent visits, in principle once a week and not less than once a month, in circumstances that respect the need of the juvenile for privacy, contact and unrestricted communication with the family and defence counsel)
- Rule 61 (every juvenile should have the right to communicate in writing or by telephone, in principle at least twice a week, and to receive correspondence)
- Rules 63 and 64 (recourse to instruments of restraint and force for any purpose should be prohibited, other than in exceptional cases, where all other control methods have been exhausted and failed, and only as explicitly authorised and specified by law and regulation. No instrument of restraint or force should cause humiliation or degradation, and should be used restrictively and only for the shortest possible period of time)
- Rule 66 (all disciplinary measures should be consistent with the upholding of the juvenile's inherent dignity and the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person)
- Rule 67 (all disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned)

- Rule 70 (no juvenile should be disciplinarily sanctioned except in strict accordance with the terms of law and regulations in force. No juvenile should be sanctioned unless he or she has been informed of the alleged infraction in a manner appropriate to the juvenile's full understanding, and given a proper opportunity of presenting his or her defence, including the right of appeal to a competent and impartial authority. Complete records should be kept of all disciplinary proceedings)
- Rule 71 (no juveniles should be responsible for disciplinary functions except in the supervision of specified social, educational or sports activities or in self-government programmes)
- Rule 81 (personnel should be qualified and include a sufficient number of specialists such as educators, vocational instructors, counsellors, social workers, psychiatrists and psychologists)
- Rule 82 (the administration should provide for the careful selection and recruitment of every grade and type of personnel, since the proper management of detention facilities depends on their integrity, humanity, ability and professional capacity to deal with juveniles, as well as personal suitability for the work)
- Rule 86 (the director of a facility should be adequately qualified for his or her task, with administrative ability and suitable training and experience)
- Rule 87 (in the performance of their duties, personnel of detention facilities should respect and protect the human dignity and fundamental human rights of all juveniles).[64]

115. The above requirements are basic and obvious. It is concerning that despite the State being aware of abuse at Whakapakari , authorities sent children and young people there for more than two decades.

116. Further, regulations such as the Children and Young Persons (Residential Care) Regulations 1986 and the Children, Young Persons, and Their Families (Residential Care) Regulations 1996 set out a series of rights and other protections for children and young people in social welfare institutions, many of which correspond with the United Nations Rules. However, those regulations did not apply beyond social welfare institutions.[65] This meant that section 396 providers such as Te Whakapakari Youth Trust were not subject to these regulations, and children and young people sent to those providers did not have the protection of them.

64 United Nations Rules for the Protection of Juveniles Deprived of their Liberty (4 December 1990), General Assembly resolution 45/113.

65 See the definition of 'institution' in the Children and Young Persons (Residential Care) Regulations 1986, regulation 2, and the definition of 'residence' in the Children, Young Persons, and Their Families (Residential Care) Regulations 1996, regulation 2.

Kimberley Centre ki Taitoko
Kimberley Centre in Taitoko Levin

117. The Inquiry found evidence of rape and other sexual abuse at Kimberley Centre as set out in the case study. Kimberley survivors cowered and cringed if they were approached quickly (the 'Kimberley cringe'), demonstrating long-standing and systemic physical abuse against those in care. The Inquiry also found evidence of serious physical assaults against children, young people and adults in care by staff and by peers. There was evidence of pervasive neglect including in relation to three choking deaths in the late 1990s,[66] and in relation to the personal care required to maintain the dignity of residents and avoid their humiliation. Some residents were subjected to long periods of solitary confinement.[67]

118. Kimberley Centre was a place of systemic abuse. Many Kimberley residents were there for life, starting from when they were young children. Others resided there for very long periods. Many residents were therefore exposed to abuse for a lifetime, or for years and years. This abuse would have had a cumulative impact.

119. These matters also give rise to very serious issues of cruel, inhuman or degrading treatment or punishment.

Te kaha o te tūkino i ngā tamariki me ngā tāngata whaikaha
Serious abuse against children and the disabled

120. It cannot be emphasised enough that many of the victims of abuse and neglect, including of serious abuse, were children. Children are vulnerable simply because of their age. Those in care were often extremely vulnerable because of the circumstances that led them to being in care. There was an even greater vulnerability for disabled children. Similar considerations apply in respect of disabled people more generally and adults in care.

121. The vulnerability and susceptibility of those abused in care only increases the reprehensibility of that abuse.[68]

66 See Royal Commission of Inquiry into Abuse in Care, "Out of sight, out of mind," A case study of the Kimberley Centre, a 'psychopaedic institution for people with a learning disability (2024, chapter 4. page 12).
67 See Royal Commission of Inquiry into Abuse in Care, "Out of sight, out of mind," A case study of the Kimberley Centre, a 'psychopaedic institution for people with a learning disability (2024, chapter 4. page 15).
68 57 Butler, A & Butler, P, The New Zealand Bill of Rights Act: A Commentary (2nd edition, LexisNexis, 2015, para 10.16.1).

Te kore whai i te ara mōtika tangata ki te taurimatanga
Failure to take a human rights approach to care

122. Care was not generally understood as an environment in which human rights were at risk. The reasons for this include that too much trust was placed in care providers and other people in authority and those in care were often distrusted, as well as the limited visibility of human rights in Aotearoa New Zealand in relation to care referred to above. They also include perhaps a desire among many to believe that human rights abuses are something that happen overseas, not here. That belief is wrong. Not only has it produced complacency, but it has also allowed abuse and neglect allegations to be ignored or inadequately investigated.

123. While Aotearoa New Zealand often says that it is committed to human rights, its lack of adherence to many recommendations made by UN human rights committees as referred to in Part 7 suggests otherwise. The Inquiry is also not aware of the State carrying out any systematic, regular monitoring of care against human rights standards to determine whether that commitment was being met in practice. There was no developed, specific framework aimed at ensuring that human rights in all care settings were respected, protected and fulfilled. This remains the case today, and there is no Aotearoa New Zealand-specific, human rights approach to care.

He waiata aroha mō ngā purapura ora

Kāore te aroha i ahau mō koutou e te iwi I mahue kau noa
i te tika
I whakarerea e te ture i raurangi rā Tāmia rawatia ana te
whakamanioro
he huna whakamamae nō te tūkino
he auhi nō te puku i pēhia kia ngū
Ko te kaikinikini i te tau o taku ate tē rite ai ki te kōharihari o tōu
Arā pea koe rā kei te kopa i Mirumiru-te-pō
Pō tiwhatiwha pōuri kenekene
Tē ai he huringa ake i ō mahara
Nei tāku, 'kei tōia atu te tatau ka tomokia ai'
Tēnā kē ia kia huri ake tāua ki te kimi oranga
E mate Pūmahara? Kāhorehore! Kāhorehore!
E ara e hoa mā, māngai nuitia te kupu pono i te puku o Kareāroto
Kia iri ki runga rawa ki te rangi tīhore he rangi waruhia ka awatea
E puta ai te ihu i te ao pakarea ki te ao pakakina
Hei ara mōu kei taku pōkai kōtuku ki te oranga
E hua ai te pito mata i roto rā kei aku purapura ora
Tiritiria ki toi whenua, onokia ka morimoria ai
Ka pihi ki One-haumako, ki One-whakatupu
Kei reira e hika mā te manako kia ea i te utu
Kia whakaahuritia tō mana tangata tō mana tuku iho nā ō rau kahika
Koia ka whanake koia ka manahua koia ka ngawhā
He houkura mārie mōwai rokiroki āio nā koutou ko Rongo
Koia ka puta ki te whaiao ki te ao mārama
Whitiwhiti ora e!

– Paraone Gloyne

A Love Song for the Living Seeds

The love within me for you, the people, remains unchanged

Left alone, abandoned by justice and order

Subjected to the silent suffering of mistreatment

A heaviness in the core, silenced into stillness

The gnawing of my heart cannot compare to the anguish of yours

Perhaps you are hidden in the depths of the night, Mirumiru-te-pō

A night dark and dense

Where there may be no turning in your memories

But here's my thought: 'Do not push open the door to enter'

Instead, let us turn to seek life and well-being

Is memory dead? No, certainly not!

Arise, friends, let the truth resound loudly from the heart of Kareāroto

To ascend to the clear skies, a sky washed clean at dawn

Emerging from the troubled world to a world of promise

A path for you, my flock of herons, to life

So, the precious core may blossom within you, my living seeds

Scattered across the land, cherished and growing in abundance

Rising in One-haumako, in One-whakatupu

There, my friends, lies the hope to fulfil the cost

To restore your human dignity, your inherited mana from your ancestors

Thus, it will thrive, flourish, and burst forth

A peaceful feather, a treasured calm, a serene peace from Rongo

Emerging into the world of light, into the world of understanding

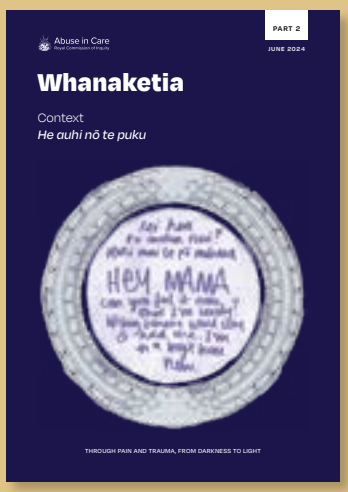
A crossing of life indeed!

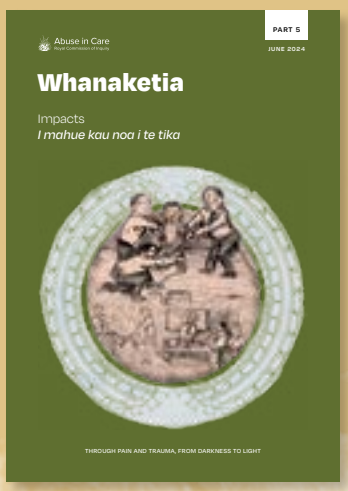
– Paraone Gloyne

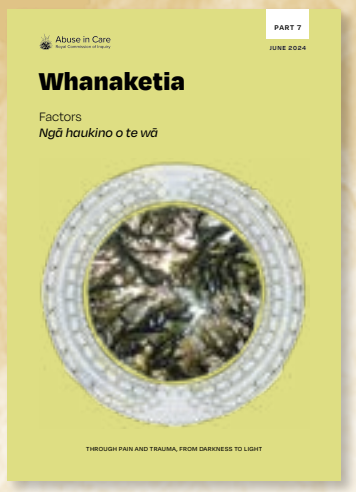
Whanaketia

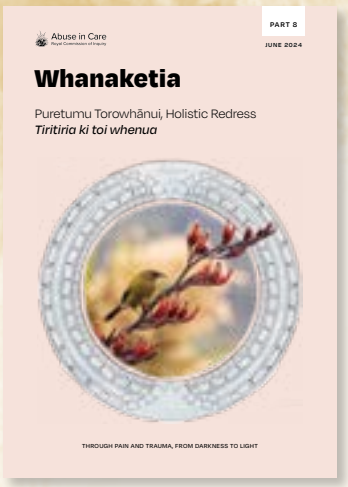
The report is made up of a preliminary, nine parts and five case studies. Whanaketia should be read in full, along with the other reports from the Commission to understand the overall picture of abuse in State and faith-based care from 1950 to 1999.

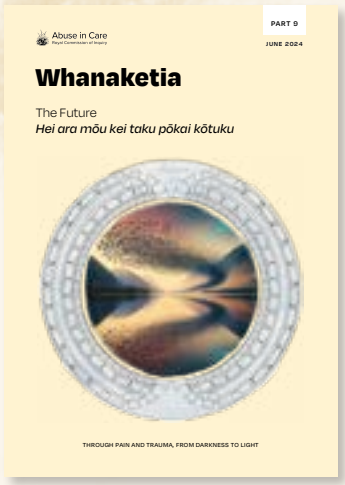
THROUGH PAIN AND TRAUMA, FROM DARKNESS TO LIGHT











Abuse in Care
Royal Commission of Inquiry