Presbyterian Support Southland Response to the Royal Commission Recommendations on Abuse in Care for faith-based originations

Recommendation	Accepted	Accepted in principal (more information needed prior to being able to agree)	Rejected and why	Plan or what is needed **Note:** as we are contracted to Oranga Tamariki much of this work will need to done in conjunction with them as we have National Care Standards we deliver services to
Recommendation 3 **Public acknowledgments and apologies for historical abuse and neglect in the care of the State (both direct and indirectly provided care) and faith-based institutions should be made to survivors, their whānau and support networks by:** **a.** the most senior leaders of all faith-based institutions and without limitation **b.** the Chief Executive Officer (or equivalent) of each individual Presbyterian Support Organisation should make public apologies and acknowledgements for abuse and neglect in the care of their respective Presbyterian Support organisation	✓			**a.** PSNZ is working together on a public apology. Completion planned for end of September. **b.** PSS apology planned to be released mid-September.
Recommendation 5 **All entities that provide care, or have provided care, directly or indirectly on behalf of the State and faith-based entities, local authorities and any other relevant entities should:**	✓			**Being reviewed by:** Marketing Communications and Fundraising Manager, PSS Chief Executive and Director Family Works

proven perpetrators and institutions where abuse and neglect took place. **a.** review the appropriateness of any streets, public amenities, public honours or any memorials named after, depicting, recognising or celebrating a proven perpetrator of abuse and neglect in care and/or an institution where proven abuse and neglect took place **b.** consider what steps may be taken to change the names and what else should be done address the harm caused to survivors by the memorialisation of				**Completion by:** end of October 2024
Recommendation 6 **Where there are reasonable grounds to believe that torture or cruel, inhuman or degrading treatment or punishment have occurred in care directly or indirectly on behalf of the State or faith-based entities, and the relevant allegations have not been investigated by NZ Police or credible new information has arisen since the allegations were investigated, NZ Police should:** a. open or re-open independent and transparent criminal investigations into possible criminal offending b. proactively and widely advertise the intent to investigate and ongoing investigations c. provide appropriate assistance and support to survivors, their whānau and support networks who contact them in relation to the investigations. **Recommendation 7** **Where there are reasonable grounds to believe that torture, or cruel, inhuman, or degrading treatment or punishment have occurred in care, the State, faith-based institutions and indirect care providers should:**	✓	✓		We will do all we can to support survivors who may wish to raise matters with the police as we have done in the past. Further work is needed internally and in conjunction with legal advice to understand What is required and how best to input into policy, procedure and practice documents.

a. provide reasonable assistance to any NZ Police investigation **b.** take all reasonable steps to ensure an impartial and independent investigation is carried out by an appropriate investigator **c.** if there is credible evidence of breaches of the law (including breaches of human rights), ensure that appropriate redress is provided to the survivors, consistent with applicable domestic and/or international obligations **d.** use best endeavours to have the liability of every relevant institution in relation to such acts determined. This may include: **i.** seeking opinions from King's Counsel, which are then shared with relevant survivors, on the nature of the conduct and the liability of relevant institutions, including as applicable under the New Zealand Bill of Rights Act 1990. Consideration may also be given to seeking declaratory judgments from the courts. Survivors should be fully supported to take part in these initiatives, including with funding for legal and other expenses **ii.** not pleading limitation defences in cases brought by survivors, for as long as limitation defences remain available.				**Being reviewed by:** PSS Chief Executive, Director Family Works and Legal representative **Completed by:** end of May 2025

Recommendation 8 **The government should take all practicable steps, including incentives and, if necessary, compulsion, to ensure that faith-based institutions and indirect care providers join the puretumu torowhānui system and scheme once it is established**		✓ We agree a scheme will bring consistency to redress for survivors but have some reservations as the full details on it are unknown. Survivors we have worked with have been positively assisted by our process and we believe we do this well. They have benefitted because we had the opportunity to demonstrate to them the opposite of what they experienced as children,		Once we know the full details on the proposed **puretumu torowhānui system** then we can advise if we agree. **Feedback to be provided by:** PSS Chief Executive

		building trust, working with their trauma and assisting on their journey of healing. Also, current ACC process for those who have been sexually abused often leaves survivors feeling further traumatized and reabused, so we have some reservations. The financial implications of the scheme are not known yet either. We need to stay viable to assist families today and into the future.		
Recommendation 9 **Representatives of faith-based institutions and indirect care providers should meet with relevant State**	✓			We are happy to work with who we need to for promotion of the Puretumu Torowhanui

representatives and agree on what steps they can take, whether separately or together, to ensure that survivors, their whānau and support networks are made aware of the puretumu torowhānui system and scheme and support options available to them.				system and ensure survivors, their whanau and support networks are also aware of support options available to them if it is decided to establish this.
Recommendation 20 **State and faith-based entities The government and faith-based institutions should jointly establish a fund to provide contestable funding for projects that promote effective community healing from the collective impacts of abuse and neglect in care, like those established in Canada and Australia. The entity holding and distributing the funding should be independent from.**			While we may acknowledge the value of this initiative we would need to know more about the commitment to this before we can advise our position. As an NGO with very limited funding to do our current work in the community, and we've already had significant funding cuts from government for the work we do.	Subject to further consideration, we can then advise if we agree. **Feedback to be provided by:** PSS Chief Executive

Recommendation 39 **The State, faith-based entities (including indirect care providers) and others involved in the care system should be guided by the following Care Safety Principles for preventing and responding to abuse and neglect when making decisions, performing functions, or exercising powers and duties in relation to the care of children, young people and adults in care:** **a.** Care Safety Principle 1: The care system should recognise, uphold and enhance the mana and mauri of every person in care **i.** each person in care lives free from abuse and neglect and their overall oranga, (wellbeing) is supported in a holistic way **ii.** care providers understand and provide for each person and their unique strengths, needs and circumstances **iii.** the importance of whānau and friendships is recognised and support from family, support networks and peers is encouraged, to enable people in care to be less isolated and connected to their community **iv.** people in care are celebrated and nurtured. **b.** Care Safety Principle 2: People in care should participate in and make decisions affecting them to the maximum extent possible and be taken seriously: **i.** people in care can participate in decisions that affect their lives, with the assistance of decision-making supports and/or an independent advocate they have chosen, where required **ii.** people in care can access abuse and/or neglect prevention programmes and information **iii.** staff and care workers are aware of signs of abuse and/or neglect and facilitate ways for people in care to	✓ (a) i ✓ (b)			In place via care standards and policies and procedures. Audited internally and externally. In place via care standards and policies and procedures. Audited internally and externally ii & iv need to be developed. **Completed by:** end of June 2025 **By:** Family Works Care team and management

raise concerns **iv.** people who are currently or have previously been in care can participate in decision-making and policymaking about the care system. **c.** Care Safety Principle 3: Whānau and support networks should be involved in decision-making processes wherever possible and appropriate: **i.** connections between people in care and their whānau and support networks are actively supported, and whānau and support networks can participate in decisions affecting the person in care wherever possible and appropriate **ii.** care providers engage in open communication with whānau and support networks about their abuse and neglect prevention approach **iii.** whānau and support networks are informed about and can have a say in organisational and system-level policy **iv.** whānau, hapū, iwi and Māori can participate in decision-making processes about their mokopuna and uri. **d.** Care Safety Principle 4: The State, faith-based entities (including indirect care providers) and others involved in the care system should give effect to te Tiriti o Waitangi and enable Māori to exercise tino rangatiratanga: **i.** whānau, hapū, iwi and Māori exercise the right to tino rangatiratanga over kāinga and are empowered to care for their tamariki, rangatahi, pakeke Māori and whānau according to their tikanga and mātauranga **ii.** the Crown actively devolves to Māori policy and investment decisions about the care system, design and delivery of supports and services for, and specific care decisions about, tamariki, rangatahi and pakeke Māori	✓ C ✓ (d)			In place via care standards and policies and procedures. Audited internally and externally. ii & iii need to be developed. **Completed by:** end of June 2025 **By:** Family Works Care team and management All of (d) requires further exploration with Ngai Tahu, ourselves and Oranga Tamariki nationally. We have sought clarification from OT whether they intend to respond to the RC recommendations and as to how we will work together where relevant due to the National Care Standards which apply to foster care contracts with Oranga Tamariki. We are yet to hear back.

iii. until the realisation of principle 4(ii), Māori and the Crown should collaborate on policy and investment decisions about the care system, the design and delivery supports and services for, and specific care decisions about, tamariki, rangatahi and pakeke Māori **iv.** tamariki, rangatahi and pakeke Māori who need care live as Māori and are connected to their whānau, hapū, iwi, whakapapa, whenua, reo and tikanga **v.** wellbeing for tamariki, rangatahi and pakeke Māori is understood and supported through an ao Māori worldview, encompassing tapu, mana, mauri and wairua.				**Reviewed by:** Family Works care team and management with PSS Pou Tohutohu Ahurea Maori and Oranga Tamariki nationally **Completed by:** end of June 2025
e. Care Safety Principle 5: Abuse and neglect prevention should be embedded in the leadership, governance and culture of all State and faith-based entities (and indirect care providers) involved in the care system, including government agencies, faith leaders, care providers and staff and care workers: **i.** leaders across the care system champion the prevention of abuse and neglect in care **ii.** prevention of abuse and neglect is a shared responsibility at all levels of the care system **iii.** governance arrangements in agencies and entities ensure implementation of measures to prevent abuse and neglect in care and there are accountabilities and obligations set at all levels **iv.** risk management strategies focus on abuse and neglect prevention **v.** codes of conduct set clear behavioural expectations of all staff and care workers.	✓ E			A review is required of what we have n place to ensure there is coverage across our organisation from Board to ground staff. **Reviewed by:** Trust Board, PSS Chief Executive and Family Works management **Completed by:** end of June 2025
f. Care Safety Principle 6: Care providers should recognise, uphold and implement human rights standards and obligations and the Enabling Good Lives principles, and recognise and provide for diverse needs	✓ F			A review is required of what we have in place and ensure key focus areas as noted are in place.

including Deaf and disabled people and people experiencing mental distress: **i.** people in care are supported and provided accessible information to understand their rights **ii.** care providers have human rights standards embedded in their policies and practice **iii.** care providers understand people's diverse circumstances and respond effectively to people who are at increased risk of experiencing abuse and/or neglect **iv.** Enabling Good Lives principles underpin all support for disabled people, including culturally appropriate support as determined by whānau hauā, tāngata whaikaha and tāngata whaiora, to enable and empower disabled people to live well, participate in their community without segregation or institutionalisation and make decisions about their lives. **g.** Care Safety Principle 7: Staff and care workers should be suitable and supported: **i.** all stages of recruitment, including advertising and screening, emphasise the values of caring for people in care, safety of people in care and prevention of abuse and neglect **ii.** staff and care workers have regularly updated safety checks **iii.** staff and care workers receive appropriate induction and training and are aware of their responsibilities to prevent abuse and neglect, including reporting obligations **iv.** staff and care workers receive appropriate training to ensure they have cultural competency **v.** education programmes for staff and care workers include units focused on understanding and preventing	✓ G			**Reviewed by:** Family Works care team and management and PSS Pou Tohutohu Ahurea Maori **Completed by:** end of June 2025 A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works care team, management and Director of People, Culture and Safety **Completed by:** end of June 2025

abuse and neglect in care **vi.** supervision and people management include a focus on preventing abuse and neglect. **h.** Care Safety Principle 8: Staff and care workers should be equipped with the knowledge, skills and awareness to keep people in care safe through continuous education and training: **i.** staff and care workers receive training on the nature and signs of abuse and neglect in care **ii.** staff and care workers receive training on organisational and national abuse and neglect prevention policies and practices **iii.** staff and care workers are supported to develop practical skills in safeguarding children, young people and adults in care **iv.** staff and care workers have the appropriate cultural knowledge. **i.** Care Safety Principle 9: Processes to respond to complaints of abuse and neglect and neglect should respond appropriately to the person (e.g. child-focused or young person-focused or adult in care-focused) in a timely manner: **i.** everyone in care and their whānau and support networks have access to information, decision-making supports to engage in complaints processes **ii.** care providers have complaint handling policies appropriate for the people in care which clearly outline roles and responsibilities, approaches for responding to complaints and obligations to act and report **iii.** effective complaints processes are understood by people in care, staff and volunteers and whānau and support networks and are culturally appropriate **iv.** complaints are taken seriously, responded to promptly	✓ H ✓ I			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works care team, management and Director of People, Culture and Safety **Completed by:** end of June 2025 A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works care team, management and Director of People, Culture and Safety **Completed by:** end of June 2025

and thoroughly, and reporting, privacy and employment law obligations are met. **j.** Care Safety Principle 10: Physical and online environments should minimise the opportunity for abuse and neglect to occur: **i.** risks in online and physical environments are mitigated whilst upholding the right to privacy and ensuring wellbeing of people in care **ii.** online environments are used in accordance with organisations' code of conduct. **k.** Care Safety Principle 11: Standards, policy and practice should be continuously reviewed, including from time to time independently reviewed, and improved: **i.** care providers regularly review standards, policy and practice to prevent and improve responses to abuse and neglect in care **ii.** complaints and concerns are analysed to identify systemic issues, both within organisations and within the care system as a whole **iii.** people who are currently or have previously been in care are enabled to participate in reviews of standards, policy, practice. **l.** Care Safety Principle 12: Policies and procedures should document how each care provider will ensure that people in care are safe: **i.** safeguarding practice is prioritised and integrated throughout the organisation **ii.** policies and procedures embed safeguarding and abuse and neglect prevention measures policies and procedures are accessible and easy to understand **iii.** stakeholder consultation informs the development of policies and procedures **iv.** leaders champion and model compliance with policies	✓ J ✓ K ✓ L			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works care team, management and Manager Marketing Fundraising and Communication **Completed by:** end of June 2025 A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works care team and management **Completed by:** end of June 2025 A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works care team and management, Chief Executive and Trust Board for feedback **Completed by:** end of June 2025

and procedures **v.** staff and care workers understand and implement the policies and procedures.				
Recommendation 50 **The leaders of all State and faith-based entities providing care directly or indirectly should ensure there is effective oversight and leadership of safeguarding at the highest level, including at governance or trustee level where applicable.**	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Trust Board, PSS Chief Executive and Family Works Director **Completed by:** end of June 2025
Recommendation 51 **The leaders of all State and faith-based entities providing care directly or indirectly should ensure that safeguarding is a genuine priority for the institution, key performance indicators are in place for senior leaders, and sufficient resources are available for all aspects of safeguarding.**	✓			**Reviewed by:** Trust Board, PSS Chief Executive, Director People, Culture and Safety and Family Works Director **Completed by:** end of June 2025
Recommendation 52 **All State and faith-based entities providing care directly or indirectly should ensure they collect adequate data on abuse and neglect in care and regularly report to the governing bodies or leaders of each institution, based on that data, so they can carry out effective oversight of safeguarding.**	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Trust Board, PSS Chief Executive and Family Works Director **Completed by:** end of June 2025

Recommendation 53 **The leaders of all State and faith-based entities providing care directly or indirectly should ensure staffing, remuneration and resourcing levels are sufficient to ensure the effective implementation of safeguarding policies and procedures.**	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** PSS Chief Executive, Director People, Culture and Safety and Family Works Director **Completed by:** end of June 2025
Recommendation 54 **The senior leaders of all State and faith-based entities providing care directly or indirectly to children, young people and adults should take active steps to create a positive safeguarding culture, including by:** **a.** designating a safeguarding lead with sufficient seniority **b**. supporting the prevention, identification and disclosure of abuse and neglect **c.** ensuring the entity providing care directly or indirectly complies with its health and safety obligations **d.** protecting whistleblowers and those who make good-faith notifications **e.** ensuring accountability for those who fail to comply with safeguarding obligations **f.** prioritising and supporting training and professional development in safeguarding and in abuse and neglect in care including the topics set out in Recommendation 63 **g.** actively promoting a culture that values all children, young people and adults in care and addresses all forms of discrimination **h**. ensuring there are sufficient resources for	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** PSS Chief Executive, Director People, Culture and Safety and Family Works Director **Completed by:** end of June 2025

safeguarding **i.** identifying and correcting harmful attitudes and beliefs, such as the disbelief or mistrust of complainants or racist or ableist actions and beliefs **j**. ensuring there is adequate data collection and information on abuse and neglect in care, including relevant data on ethnicity and disability, to allow analysis and reporting **k.** learning from any incidents and allegations **l. publicly reporting on the matters including any issues arising n relevant annual reports.**				
Recommendation 55 **All State and faith-based entities providing care directly or indirectly should have safeguarding policies and procedures in place that:** **a.** are consistent with the Care Safety Principles (Recommendation 39) **b.** are consistent with the National Care Safety Strategy (Recommendation 40) **c.** are compliant with care safety rules and standards (Recommendation 47) **d.** are consistent with best practice guidelines issued by the Care Safe Agency **e.** are tailored to the risks of the particular organisation and care provided **f.** are clearly written **g.** are published in a readily accessible format **h**. give effect to te Tiriti o Waitangi **i.** are culturally and linguistically appropriate **j.** are responsive to the needs of children, young people and adults in care, including Māori, Pacific Peoples, Deaf, disabled and people experiencing mental distress, and	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** PSS Chief Executive, Director People, Culture and Safety, Pou Tohutohu Ahurea Maori , Family Works Director and management **Completed by:** end of June 2025

Takatāpui, Rainbow and MVPFAFF+ people **k**. are regularly reviewed, including periodic external reviews **l.** are audited for compliance, including periodic external audits.				
Recommendation 56 **All State and faith-based entities providing care directly or indirectly should have safeguarding policies and procedures that address, at a minimum:** **a.** how the entity providing care directly or indirectly will protect children, young people and adults in care from harm **b.** how the entity providing care directly or indirectly will comply with the applicable standards and principles **c.** how people can make complaints about abuse and neglect to the entity, the Care Safe Agency or independent monitoring entities (Recommendation 65) **d.** how complaints, disclosures and incidents will be investigated and reported, including reporting to the Care Safe Agency, professional bodies or NZ Police and other authorities (Recommendation 65) **e.** the protections available to whistleblowers and those making good faith notifications of abuse and neglect **f.** how the entity providing care directly or indirectly will use applicable information-sharing tools. **g.** how the entity will publicly and regularly report on these matters.	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Trust Board, PSS Chief Executive, Director People, Culture and Safety,Family Works Director and management **Completed by:** end of June 2025

Recommendation 59 **All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure all prospective staff, volunteers and any other person working with children, young people or adults in care ('prospective staff') have a satisfactory report from the applicable vetting regime and up to date registration status.**	✓			This is currently in place, with clarification needed around volunteers and staff who can't be registered.
Recommendation 60 **All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure their pre-employment screening checks include:** **a.** thorough reference checks, including asking direct questions about any concerns about the applicant's suitability to work with children, young people or adults in care **b.** employment interviews that focus on determining the applicant's suitability to work with children, young people or adults in care **c.** critically examining an applicant's employment history and/or written application (for example to identify and seek an explanation for gaps in employment history, or to explain ambiguous responses to direct questions about criminal history) **d.** verifying the applicant's identity, education and qualifications **e.** assessing the ability of caregivers, including foster parents and volunteers, to build relationships and provide consistent, sensitive and responsive care,	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Director People, Culture and Safety, Family Works Director and management and Pou Tohutohu Ahurea Maori **Completed by:** end of June 2025

including being able to meet the cultural needs of the people they care for.				
Recommendation 62 **All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should recruit for and support a diverse workforce, including in leadership and governance roles, so far as practicable reflecting the care communities they serve and care for.**		✓		We do our best across all areas we provide services
Recommendation 63 **All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure:** **a.** they have a code of conduct in place, which requires those providing care to comply with applicable safeguarding policies and procedures **b.** all staff, volunteers and any others (ordained and non-ordained) working with children, young people or adults in care ("staff and care workers") receive an induction promptly after they begin their employment and are aware of their safeguarding responsibilities including reporting obligations **c.** supervisors and people leaders have a safeguarding focus **d.** all staff receive training that ensures understanding about the Care Safety Principles (Recommendation 39),	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Director People, Culture and Safety, Family Works Director and management and Pou Tohutohu Ahurea Maori **Completed by:** end of June 2025

the National Care Safety Strategy (Recommendation 40), and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting **e.** all staff are trained and kept up to date in applicable safeguarding policies, procedures and practices **f.** all staff receive up to date training on how to identify and prevent abuse and neglect **g.** all staff are trained in appropriate trauma informed practice, disability informed practice, an understanding of neurodiversity, te Tiriti o Waitangi, Māori cultural practices, Pacific and ethnic cultural practices, human rights and an understanding of abuse and neglect in care both historically and present-day **h.** all staff are trained to identify and address (in themselves and others) prejudice and all forms of discrimination **i.** all staff are provided with support, supervision, training and professional development on a frequent and regular basis, to ensure they are able to develop and maintain their capacity to provide reliable, sensitive and responsive care to the people they are looking after **j.** all staff receive appropriate professional development support, including how to protect children, young people and adults in care from abuse and neglect and respond to disclosures **k.** there are no adverse employment or other consequences for those making good faith notifications or disclosures of abuse and neglect.				
Recommendation 64				

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure that the same rules and standards in relation to vetting, registration, training and working conditions that apply to employees, apply equally to volunteers or others with equivalent access to children, young people and adults in care. Faith-based entities should ensure the same rules apply to people in religious ministry and lay volunteers as to employees.		✓ Although we have most of this in place there are some areas that need further clarification e.g. registration of volunteers		
Recommendation 65 **All State and faith-based entities providing care directly or indirectly to children, young people and adults in care and relevant professional registration bodies should ensure they have appropriate policies and procedures in place to respond in a proportionate way to complaints, disclosures or incidents of abuse and neglect, including:** **a.** the policies and procedures are guided by the Care Safety Principles (Recommendation 39) and any relevant rules, standards or guidelines issued by the Care Safe Agency (Recommendation 41) **b.** the policies and procedures are clearly written, accessible to people in care, their whānau and support networks, and to staff and care workers, and are kept up to date **c.** the policies, at a minimum, outline roles and responsibilities, how different types of complaints will be handled, including potential employment outcomes and	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Director People, Culture and Safety, Family Works Director and management and Pou Tohutohu Ahurea Maori **Completed by:** end of June 2025

reporting obligations **d.** the policies set out how actual or perceived conflicts of interest will be addressed if they arise **e.** there are clear protections in place for whistleblowers and those making good faith notifications **f.** it is as easy as possible for people to make disclosures or complaints **g.** complaints processes are appropriate for Māori, Pacific People, Deaf and disabled people, people who experience mental distress and Takatāpui, Rainbow and MVPFAFF+ people including ensuring there is access to appropriate support **h.** complainants are supported and kept informed throughout the handling of their complaint, including with the assistance of their independent advocates (Recommendation 76) if applicable **i.** complainants are kept safe throughout the handling of their complaint, including if they have complained about another person in care or a person who directly provides them care **j.** complaints are responded to promptly and robustly, including: **i.** as soon as a complaint is made, carrying out an initial risk assessment to identify the risks to the complainant and to other children, young people and adults in care **ii.** mitigating identified risks while the complaint is being investigated, proportionate to the seriousness of the allegation **iii.** continuing to investigate and report on complaints even if the subject of the complaint voluntarily leaves employment and/or cancels their professional registration **iv.** carrying out a robust investigation at a level				

proportionate to the seriousness of the complaint **v.** applying a standard of proof consistent with civil law ("on the balance of probabilities") when investigating complaints, but doing so flexibly, proportionate to the seriousness of the allegation **vi.** using external investigators where appropriate for the most serious allegations **vii.** meeting all privacy and employment law obligations **viii.** ensuring appropriate accountability, including through reporting to NZ Police and relevant professional registration bodies if the complaint is substantiated (Recommendation 66) **k.** all complaints must be reported to the Care Safe Agency (Recommendation 41) regardless of the outcome of the investigation **l.** each complaint must be reviewed for lessons identified and possible improvements **m.** publicly report annually on how many complaints they are dealing with, whether they have been resolved, whether they have been substantiated, and how long the complaint took to be resolved.				
Recommendation 66 **Where a complaint has been substantiated, State and faith-based entities providing care directly or indirectly and relevant professional bodies should take steps to ensure the person or people responsible are held accountable, including:** a. professional disciplinary action b. reporting to the relevant professional registration body or bodies c. reporting to the Care Safe Agency d. reporting to NZ Police	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Director People, Culture and Safety, Family Works Director and management **Completed by:** end of June 2025

e. reporting in accordance with any other applicable information sharing or mandatory reporting obligations.				
Recommendation 67 **All State and faith-based entities providing care directly or indirectly and relevant professional registration bodies should report all complaints, disclosures, or incidents to the Care Safe Agency, whether substantiated or not substantiated following investigation.**	✓			Sort process internally once this is set up. It will be necessary to establish a robust, clear and transparent process within the Care Safe Agency. **Who:** Director Family Works
Recommendation 75 **All State and faith-based entities providing direct or indirect care to children, young people and adults should review physical building and design features to identify and address elements that may place children, young people and adults in care at risk of abuse and neglect. This should include:** **a.** consideration of how best to use technology such as CCTV cameras and body cameras without unduly infringing personal privacy, including taking into account any applicable guidance documents and the legal requirements for the collection of personal information under the Privacy Act 2020 **b.** reviewing any policies or processes that place children, young people, or adults in care with **c** others who may put them at risk (for example, children and young people in care and protection being placed together with children, young people, or adults in the justice system) **c.** if care settings include physically isolated spaces, for example private offices or a confessional box, ensuring	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management **Completed by:** end of June 2025

there are tailored measures in place to address the risks arising, including the risk of undetected abuse and neglect **d.** if care is to be delivered in a geographically isolated or remote area, ensuring there are tailored measures in place to address the risks arising from the geographical setting, including the risk of undetected abuse and neglect.				
Recommendation 78 **All State and faith-based entities providing care directly or indirectly should seek the best possible understanding of the background, culture, needs and vulnerabilities of every child, young person, and adult in their care, and should include the protection and enhancement of the mana and mauri of Māori in care.**	✓			A review is required of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management **Completed by:** end of June 2025
Recommendation 79 **The government and all relevant decision-makers should review existing policy, standards, and practice to ensure that all involuntary care placements are suitable and support connection to whānau and community. This includes placements being located as close as reasonably practicable to the family or whānau of the children, young person, or adult in care**		✓		We currently do this. There are times (not often) that the availability of carers limits location. At these times the needs for a safe and caring place to be can override this practice unfortunately
Recommendation 80 **All State and faith-based entities providing care directly or indirectly should review existing policies and practice to ensure they promote and support the maintenance of connections and attachment to family and whānau wherever possible and appropriate**	✓			We currently do this. We will review to ensure it is explicit in our policies. **Reviewed by:** Family Works Director and management

				Completed by: end of June 2025
Recommendation 81 **All State and faith-based entities directly or indirectly providing care to children, young people, Deaf people, disabled people, and people who experience mental distress should adopt and comply with best practice guidelines for record keeping and data sovereignty, including the following principles:** **a.** Record-keeping Principle 1: To create and keep full and accurate records. Creating and keeping full and accurate records relevant to safety and wellbeing is in the best interests of children, young people or adults in care and should be an integral part of institutional leadership, governance, and culture. Institutions that care for or provide services to children, young people or adults in care must keep the best interests of the child uppermost in all aspects of their conduct, including recordkeeping. It is in the best interest of children, young people, or adults in care that institutions foster a culture in which the creation and management of accurate records, including detailed information about ethnicity and impairments, are integral parts of the institution's operations and governance. **b.** Record-keeping Principle 2: Records to include all incidents and responses. Full and accurate records should be created about all incidents, responses and decisions affecting the safety and wellbeing, including abuse and neglect in care, of children, young people, or adults in care. Institutions should ensure that records are created to document any	✓			A review is required of our policies, procedures, care plans, data bases (Infoodle and Paua) and historic complaints location **Reviewed by:** Family Works Director and management **Completed by:** end of June 2025

identified incidents of grooming, inappropriate behaviour (including breaches of institutional codes of conduct) or abuse and neglect in care and all responses to such incidents. Records created by institutions should be clear, objective, and thorough. They should be created at, or as close as possible to, the time the incidents occurred, and clearly show the author (whether individual or institutional) and the date created. **c.** Record-keeping Principle 3: Records to be maintained in an indexed, logical and secure manner. Records relevant to the safety and wellbeing of children, young people or adults in care, including abuse and neglect in care, should be maintained appropriately and in an indexed, logical and secure manner. Associated records should be co-located or cross-referenced to ensure that people using those records are aware of all relevant information. **d.** Record-keeping Principle 4: Records only be disposed of in accordance with law or policy. Records relevant to the safety and wellbeing, including abuse and neglect in care, of children, young people or adults in care should only be disposed of in accordance with law or policy. Records relevant to the safety and wellbeing, including abuse and neglect in care, of children, young people or adults in care must only be destroyed in accordance with records disposal schedules or published institutional policies. Records relevant to abuse and neglect in care should be subject to minimum retention periods that allow for delayed disclosure of abuse and neglect by victims and survivors and take account of limitation periods for civil actions for abuse and neglect in care. **e.** Record-keeping Principle 5: Individuals' rights to				

access, amend or annotate records about themselves to be recognised to the fullest extent Individuals' existing rights to access, amend or annotate records about themselves should be recognised to the fullest extent including in a way that is compliant with the Convention on the Rights of Persons with Disabilities. Individuals whose childhoods are documented in records held by all entities providing care directly or indirectly should have a right to access records made about them. Full access should be given unless contrary to law. This includes the right to access records without redaction. Specific, not generic, explanations should be provided in any case where a record, or part of a record, is withheld or redacted. Consent of the person who is currently or was previously in care should be proactively sought if information needs to be shared with family members.				
Recommendation 82 **All State and faith-based entities providing care directly or indirectly to children, young people or adults should, together with the person in care, document an account of their life during their time in care.**	✓			For children and young people in our care we complete a Life Story Book with them
Recommendation 83 **All State and faith-based entities providing care directly or indirectly to children, young people or adults should be required to retain records relating to alleged abuse and neglect in care for at least 75 years in a separate central register, to allow for delayed disclosure and redress claims or civil litigation.**	✓			We currently keep care records indefinitely This would be part of what we would keep. We believe we need to keep information for past people in care so they can know their story should they wish to. We will review our policy though to ensure this is clear and we may need to think about the number of years to

				keep them overall as 75 seems a reasonable amount of time for all records. **Reviewed by:** Director Family Works and management **Completed by:** end of June 2025
Recommendation 89 **All faith-based entities that provide activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children, young people or adults in care, should comply with the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40) and all statutory requirements under the Care Safety Act (Recommendation 41), including care standards, accreditation and vetting. Faith-based entities in highly regulated sectors, such as schools and out-of-home care service providers, should also report their compliance to the religious organisation to which they are affiliated.**		✓		In principle agree. However, we believe those who work with people who come under the auspices of a particular religious denomination or faith would need to confirm if they were in agreement as is their area of knowledge and expertise
Recommendation 90 **All faith-based entities should adopt the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40) and all statutory requirements under the Care Safety Act (Recommendation 41), including care standards, accreditation, and vetting, for each of their affiliated institutions.**		✓		
Recommendation 91		✓		

All faith-based entities should drive a consistent approach to the implementation of the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40) and all statutory requirements under the Care Safety Act (Recommendation 41), including care standards, accreditation, and vetting, in each of their affiliated institutions.				
Recommendation 92 **All faith-based entities should work closely with the independent Care Safe Agency and independent oversight bodies to support the implementation of and compliance with the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40), and all statutory requirements under the Care Safety Act (Recommendation 41), including care standards, accreditation, and vetting, in each of their affiliated institutions.**		✓		
Recommendation 93 **All faith-based entities should ensure their religious leaders are provided with leadership training both pre- and post-appointment, including identifying, preventing, and responding to abuse and neglect in care, cultural awareness, and addressing prejudice and all forms of discrimination.**	✓			We agree but feel it is for the churches to comment further on
Recommendation 94 **All faith-based entities should ensure that religious leaders are accountable to an appropriate authority or**	✓			We agree but feel it is for the churches to comment further on

body, such as a board of management or council, for the decisions they make with respect to preventing and responding to abuse and neglect in care.				
Recommendation 95 **All faith-based entities should ensure that all people in religious or pastoral ministry, including religious leaders, are subject to effective management and oversight and undertake annual performance appraisals.**	✓			We agree but feel it is for the churches to comment further on
Recommendation 96 **All faith-based entities should ensure that all people in religious or pastoral ministry, including religious leaders, have professional supervision with a trained professional or pastoral supervisor who has a degree of independence from the institution within which the person is in ministry.**		✓		We agree but feel it is for the churches to comment further on. It is possible they may have appropriate people within their institution that meet these guidelines
Recommendation 97 **Each faith-based entity should have a policy relating to the management of actual or perceived conflicts of interest that may arise in relation to allegations of abuse and neglect in care. The policy should cover all individuals who have a role in responding to complaints of abuse and neglect in care.**	✓			This policy needs to be develoed. **Who:** Chief Executive PSS and Director Family Works
Recommendation 98				

Each faith-based entity should ensure that candidates for religious ministry undertake minimum training on preventing and responding to abuse and neglect in care and related matters, including training that: **a.** equips candidates with an understanding of the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40), and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting **b.** educates candidates on: **i.** professional responsibility, boundaries and ethics in ministry **ii.** identifying and preventing abuse and neglect in care **iii.** cultural awareness **iv.** addressing prejudice and all forms of discrimination **v.** policies regarding appropriate responses to allegations or complaints of abuse and neglect in care, and how to implement these policies **vi.** how to work with children, young people, and adults in care.	✓			We agree but feel it is for the churches to comment further on
Recommendation 99 **Each faith-based entity should require that all people in religious or pastoral ministry, including religious leaders, undertake regular training on the institution's safeguarding policies and procedures. They should also be provided with opportunities for external training on best practice approaches to people safety.**	✓			We agree but feel it is for the churches to comment further on

Recommendation 100 **Wherever a faith-based entity has children, young people, or adults in its care, they should be provided with age-appropriate prevention education that aims to increase their knowledge of abuse and neglect and build practical skills to assist in strengthening self-protective skills and strategies. Prevention education in religious institutions should specifically address the power and status of people in religious ministry and educate children, young people, and adults in care that no one has a right to invade their privacy and make them feel unsafe.**	✓			We agree but feel it is for the churches to comment further on
Recommendation 101 **All faith-based entities should revise their policies to reduce high barriers to disclosure including through flexibility for disclosures of abuse.**	✓			Review what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management **Completed by:** end of June 2025
Recommendation 102 **Each faith-based entity should make provision for family and community involvement by publishing all policies relevant to preventing and responding to abuse and neglect in care on its website, providing opportunities for comment, and seeking periodic feedback about the effectiveness of its approach to preventing and responding to abuse and neglect in care.**	✓			Review what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management **Completed by:** end of June 2025
Recommendation 103	✓			

All faith-based entities' complaint handling policies should require that, upon receiving a complaint of abuse and neglect in care, an initial risk assessment is conducted to identify and minimise any risks to children, young people, and adults in care.				Review what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management **Completed by:** end of June 2025
Recommendation 104 **All faith-based entities' complaint handling policies should require that, if a complaint of abuse and neglect in care against a person in religious ministry is credible, and there is a risk that person may encounter children in the course of their ministry, the person be stood down from ministry while the complaint is investigated.**	✓			We agree but feel it is for the churches to comment further on
Recommendation 105 **All faith-based entities should, when deciding whether a complaint of abuse and neglect in care has been substantiated, consider the principles set out by the courts in applicable case law in accordance with the seriousness of the allegation.**				We work from likelihood now for current and historic disclosures. If current, we would report to the authorities directly to follow up e.g. police and Oranga Tamariki
Recommendation 106 **All faith-based entities should apply the same standards for investigating complaints of abuse and neglect in care, whether or not the subject of the complaint is a person in religious ministry.**	✓			We agree but feel it is for the churches to comment further on
Recommendation 107	✓			

Any person in religious ministry who is the subject of a complaint of abuse and neglect in care which is substantiated on the balance of probabilities, applied flexibly according to the seriousness of the allegation in accordance with the principles set out by the courts in applicable caselaw, or who is convicted of an offence relating to abuse and neglect in care, should be permanently removed from ministry. Members of the Church should be notified of the persons permanent removal from ministry. Faith-based entities should also take all necessary steps to effectively prohibit the person from in any way holding himself or herself out as being a person with religious authority.				We agree but feel it is for the churches to comment further on
Recommendation 108 **Any person in religious ministry who is convicted of an offence relating to abuse and neglect in care should:** **a. in the case of Catholic priests and religious, be dismissed from the priesthood and/or dispensed from his or her vows as a religious** **b. in the case of Anglican clergy, be deposed from holy orders** **c. in the case of an ordained person in any other religious denomination that has a concept of ordination, holy orders and/or vows, be dismissed, deposed, or otherwise effectively have their religious status removed.**			We neither agree nor disagree. This is for each church to comment on.	
Recommendation 109 **Where a faith-based entity becomes aware that any person attending any of its religious services or activities is the subject of a substantiated complaint of abuse and neglect in care, or has been convicted of an**	✓			We agree but feel it is for the churches to comment further on

offence relating to abuse and neglect in care, the faith-based entity should: **a. assess the level of risk posed to children, young people, and adults in care by that perpetrator's ongoing involvement in the religious community** **b. take appropriate steps to manage that risk.**				
Recommendation 110 **Each faith-based entity should consider establishing a national register which records limited but sufficient information to assist affiliated institutions to identify and respond to any risks to children, young people and adults in care that may be posed by people in religious or pastoral ministry.**		✓ Legal implications need considered e.g. privacy and human rights and we need to understand how information is recorded and who it is shared with. More information is needed before we can say we agree.		
Recommendation 113 **The government and faith-based entities should disseminate and publicise the findings and Recommendations of this Inquiry in the widest and most transparent manner possible.**		✓		Clarification around what this means is needed as there are many findings and recommendations.

				Discussed and decided by: Chief Executive PSS, Marketing, Fundraising and Communication Manager and Director Family Works **Completed by:** end of November 2024
Recommendation 125 **The government and faith-based institutions should take any and all actions required to give effect to the Inquiry's Recommendations set out in this report and the Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, including changes to investment, public policy, legislation or regulations, operational practice or guidelines.**		✓ We need full clarity about what Puretumu Torowhānui will look like in relation to processes and compensation to decide if can agree to all or some of it		
Recommendation 126 **The State and faith-based entities should partner with iwi to give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples in relation to researching, designing, piloting, implementing and evaluating the Inquiry's Recommendations to ensure that the Recommendations are implemented in a manner that:** **a. reflects the rights, experiences and needs of Māori in care**		✓		A review is needed of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management and Pou Tohutohu Ahurea Maori **Completed by:** end of June 2025

b. embeds the right to tino rangatiratanga over their kāinga guaranteed to Māori in te Tiriti o Waitangi				
Recommendation 127 **Government and faith-based entities should research, design, pilot, implement and evaluate the Inquiry's Recommendations through co-design with communities, including children, young people and adults in care, survivors, Māori, Pacific Peoples, culturally and linguistically diverse communities, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+ people, to ensure that reforms:** **a.** reflect the rights, experiences and needs of people in care **b.** reflect the diversity of affected communities **c.** are tailored to reach, engage and provide access to all communities.	✓			A review is needed of what we have in place and address any gaps or enhance current practice. **Reviewed by:** Family Works Director and management, Pou Tohutohu Ahurea Maori and other experts in relevant areas **Completed by:** end of June 2025
Recommendation 130 **The government and faith-based institutions should publish their responses to this report and the Inquiry's interim reports on whether they accept each of the Inquiry's findings in whole or in part, and the reasons for any disagreement. The responses should be published within two months of this report being tabled in the House of Representatives.**	✓			**Who:** Chief Executive PSS, Marketing Communications and Fundraising Manager and Director Family Works **When by:** 2 months from when the report was tabled in the House of Representatives on 24 July 2024. Published by 24 September 2024

Recommendation 131 **The government and faith-based institutions should issue formal public responses to this report about whether each Recommendation is accepted, accepted in principle, rejected or subject to further consideration. Each response should include a plan for how the accepted Recommendations will be implemented, the reasons for rejecting any Recommendations, and a timeframe for any further consideration required. Each response should be published within four months of this report being tabled in the House of Representatives.**	✓			**Who:** Chief Executive PSS, Marketing Communications and Fundraising Manager and Director Family Works **When by:** 4 months from when the report was tabled in the House of Representatives on 24 July 2024. Published by 24 November 2024
Recommendation 133 **The government, faith-based institutions and any other agencies that implement the Inquiry's Recommendations should:** **a.** publicly report on the implementation of the Inquiry's Recommendations contained in the final report and all previous interim reports, including the implementation status of each Recommendation and any identified issues and risks **b.** publish the implementation report annually for at least 9 years, commencing 12 months after the tabling of this report in the House of Representatives and provide a copy to the Care System Office and Care Safe Agency.	✓			**Who:** Chief Executive PSS, Marketing Communications and Fundraising Manager and Director Family Works **When by:** 12 months from when the report was tabled in the House of Representatives on 24 July 2024. Published by 24 July 2025 and annually thereafter for 9 years

Recommendation 135 **The government and faith-based entities should implement the Inquiry's Recommendations within the timeframes described in this report, whilst ensuring there is open and transparent communication with communities with whom they are co-designing the future arrangements for care.**		✓ We will do our best		
Recommendation 138 **The government and faith-based institutions should publish formal responses to the independent 9-year review, indicating whether its advice on further steps is accepted, accepted in principle, rejected or subject to further consideration. Each response should include a plan for how the accepted Recommendations will be implemented, the reasons for rejecting any Recommendations, and a timeframe for any further consideration required. Each response should be published by 31 December 2033.**		✓ We need further clarification as to what this means. If it is in relation to other recommendations that may come later, we agree in principal.		