MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

24 November 2022

Tēnā koe

On 20 September 2022, you emailed the Ministry of Social Development (the Ministry) requesting, under the Official Information Act 1982 (the Act), the following information:

> *I filed an OIA to MSD on May 9 seeking reports connected to Ocasa in Dunedin.*
>
> *That OIA said two of those reports, by Te Kahui Kaha were 'out of scope' for that particular request.*
>
> *I'd like to request those reports.*

Please see enclosed the following two reports in scope of your request:

- *Accreditation Assessment Report*, dated 4 August 2022, and
- *Accreditation Assessment Report*, dated 22 May 2019.

You will note that some information is withheld under section 9(2)(a) of the Act in order to protect the privacy of natural persons. The need to protect the privacy of these individuals outweighs any public interest in this information.

Some information is withheld under section 9(2)(ba)(i) of the Act as it is subject to an obligation of confidence, and if released, could prejudice the supply of similar information in the future. The greater public interest is in ensuring that such information can continue to be supplied.

You will note that the *Accreditation Assessment Report* dated 4 August 2022 contains a section regarding complaints. Te Kāhui Kāhu heard information from current and former staff members that addressed concerns related to an ill-defined organisational structure, inadequate employment practices, and poor leadership. This information was considered during the accreditation process.

The principles and purposes of the Official Information Act 1982 under which you made your request are:

- to create greater openness and transparency about the plans, work and activities of the Government,
- to increase the ability of the public to participate in the making and administration of our laws and policies and
- to lead to greater accountability in the conduct of public affairs.

This Ministry fully supports those principles and purposes. The Ministry therefore intends to make the information contained in this letter and any attached documents available to the wider public. The Ministry will do this by publishing this letter and attachments on the Ministry's website. Your personal details will be deleted, and the Ministry will not publish any information that would identify you as the person who requested the information.

If you wish to discuss this response with us, please feel free to contact OIA_Requests@msd.govt.nz.

If you are not satisfied with this response regarding two Accreditation reports dated 4 August 2022 and 22 May 2022, in relation to OCASA, you have the right to seek an investigation and review by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz or 0800 802 602.

Ngā mihi nui

Colin Paintin

Colin Paintin
**Accreditation Manager**
**Te Kahui Kahu**

New Zealand Government

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

**Provider Legal Name:**
Rape Crisis (Dunedin) Incorporated

**Site Visit:** 01 May 2019

**Completed Date:** 22 May 2019

**NZBN Number:**
9429042815297

**RDA Number:**
11251

**Assessment Number:**
106672

# EXECUTIVE SUMMARY

Rape Crisis (Dunedin) Incorporated, has been assessed as partially meeting the standards for accreditation. Ten level 2 standards were assessed of which eight were met, and two were partially met.

| SSAS Standards | Outcome | SSAS Standards | Outcome |
|---|---|---|---|
| Client-centred services (L2) | Standard met | Governance and management structure and systems (L2) | Standard met |
| Community wellbeing (L2) | Standard met | Financial management and systems (L2) | Standard met |
| Cultural competence (L2) | Standard met | Resolution of complaints related to service provision (L2) | Standard met |
| Staffing (L2) | Standard partially met | Quality improvement (L2) | Standard met |
| Health and safety (L2) | Standard partially met | Client services and programmes (L2) | Standard met |



## Corrective action plan

### Critical actions

No critical actions have been identified during the assessment.

### Required actions

| *Standard* | *Criteria* | *Action* | *Due by* |
|---|---|---|---|
| Staffing (L2) | 6 | Staff, including volunteers and contractors who have been employed or engaged for three years must undergo a new police vet and must be completed every three years for the length of employment or engagement. Extended leave taken within this time does not extend the vetting requirement. The outstanding vetting return must be provided to the assessor as soon as it is received by Rape Crisis (Dunedin) Incorporated. | 22 August 2019 |

| | | | |
|---|---|---|---|
| Health and safety (L2) | 1 | The Health and Safety policy must be reviewed and updated to address the requirements of the Health and Safety at Work Act 2015. The Collective must ensure they are able to meet the requirements of this Act and ensure the appropriate Health and Safety positions and resposibilities are managed within the Collective. | next review |

## Strengths identified at review

The assessor spent time at this review talking with members of the collective to gain an understanding of how the organisation operates under a collective. Although generally governance would hold a different level of responsibility than the staff carrying out the day to day tasks in the case of this collective the roles are generally shared. Many of the collective members held dual roles including management associated tasks, operational delivery and governance. This does mean that every member of the collective takes responsibility for the policies and procedures, the service delivery and service quality and ensures those recruited into paid or volunteer roles have the right skills and attributes to participate in this type of work environment. Most paid members of the collective also give volunteer hours to the organisation to ensure those in need have 24 hour seven day a week access to crisis services.

## Recommendations

- Reference to Child Youth and Family in the Child Paramountcy Policy and Procedure should be updated to Oranga Tamariki – Ministry for Children. This should also include the updating the details relating to how a report of concern is made.
- It is recommended that the collective implement a review schedule to ensure that all policies and procedures are reviewed over time. This does not need to include every policy every year but should allow for additional reviews should there be a change to legislation or services provided.

## Accreditation status

**Confirmation of Accreditation at Level 2 with required actions**

## The conditions of accreditation

Rape Crisis (Dunedin) Incorporated has been accredited by List the Ministries/agencies involved in the review to deliver the following services:

Counselling and/or programmes for adult, adolescent or child perpetrators of Family Violence (Level 2)

Counselling and/or programmes for adult, adolescent or child victims of Family Violence (Level 2)

Family well-being services (Level 3)

## Action plan

Rape Crisis (Dunedin) Incorporated must carry out the two required actions identified in this report. The required actions must be completed prior to the next review which will be notified to you within the next 24 months. Evidence of completion can be provided to your assessor as soon as it's available.
Consideration should be given to the recommendations outlined in this report, carrying out the recommendations will assist the Collective to ensure quality improvements are made to the services provided by the organisation.

## OVERVIEW

This is a review assessment of Rape Crisis (Dunedin) Incorporated's accreditation status by List the Ministries/agencies involved in the review.

Rape Crisis (Dunedin) Incorporated (Rape Crisis Dunedin) provides support services to those whose lives have been affected by rape and/or sexual abuse. They provide counselling, crisis support and education, raising awareness around rape culture, the recognition of and the impacts of sexual assault and sexual abuse and how to support those who disclose.

Rape Crisis Dunedin is a registered charity that functions as a collective, meaning that all decisions made are made by consensus by all members. Almost all members within the collective are office bearers.

Day to day operations are managed by a team of part-time employees and many of these employees work in dual roles and are trained as sexual violence crisis support workers. After hours crisis support line is staffed by volunteers who are trained also trained as sexual violence crisis support workers. Volunteers become members of the collective and are therefore involved in the organisation at all levels. Funding for all the work done by Rape Crisis Dunedin is gained through a mix of government agency contracts, donations, grants and fund raising.

Rape Crisis Dunedin is currently embarking on re-branding of the organisation.

This review assessment was carried out by the Dunedin based Social Services Accreditation Assessor and included a review of Rape Crisis Dunedin documentation, review of the National Collective of Rape Crisis and Related Groups Aotearoa Inc, a visit to the Dunedin site and interviews with two counsellors, one of whom is also Health and Safety Co-ordinator and the Financial Administrator/Crisis Support Worker.

This is a Ministry of Social Development assessment.

## KEY FINDINGS

## SSAS Standard: Client-centred services (L2)

The organisation treats people with respect and delivers services in a manner that has regard for their dignity, privacy and independence.

1. The organisation promotes client-centred practice as central to its service development and delivery.

   1.1 The organisation involves its clients and stakeholders in planning, implementation, and evaluation at all levels of the service to ensure services are current and responsive.

2. The organisation provides services that are accessible to people with disability.
3. The organisation provides services that are free from any discrimination, coercion, harassment, and sexual, financial or other exploitation.
4. The organisation recognises and facilitates the right of people to advocacy and/or support persons of their choice.

### Evidence

- Interview with two Counsellors and one Support Worker
- Quality Improvement Policy and Plan
- Review of the on-site facilities
- Sighted preparations for Rape awareness week

### Exceptions

Based on the evidence provided for this review, no exceptions were identified.

### Outcome

Standard met

## SSAS Standard: Community wellbeing (L2)

The organisation provides services which reflect the principle that the welfare and interests of the child or young person are first and paramount and where the wellbeing of all is upheld.

1. The organisation provides services in a manner consistent with section 6 of the Children, Young Persons, and Their Families Act 1989 (CYP&FA), where services reflect the principle that the welfare and interests of the child or young person are the first and paramount consideration.
2. The organisation has a process for dealing with allegations of abuse and situations that raise concerns about the safety of a client or associated community member.

2.1 The process specifically includes guidelines on how the organisation makes referrals under section 15 of the CYP&FA.

3. The organisation promotes awareness of the unacceptability of abuse, ways in which abuse may be prevented, the need to report all cases of abuse and how to respond to all types of abuse. Abuse includes physical, emotional or sexual harm; ill-treatment; neglect or deprivation either passive or active.

4. The organisation promotes awareness of where a conflict between the needs of a client and others might arise, and uses a process to respond to such conflicts.

5. The organisation has a procedure to identify clients who may have limited ability to give informed consent. This procedure ensures that such clients are able to exercise the ability they have to the fullest extent possible.

6. When it is confirmed that a client has a limited ability to give informed consent, the organisation acts appropriately.
For those organisations that must comply with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, this will mean following the principles of Right 7.

## Evidence

- Interview with two Counsellors and one Support Worker
- Child Paramountcy Policy and Procedure
- Review of staff and volunteer induction process and sign off
- Review of staff work reports

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 2 | The current Child Paramountcy Policy and Procedure has references to previous organisations and outdated legislation. | Recommendation |

## Outcome

Standard met

# SSAS Standard: Cultural competence (L2)

The organisation provides services that are culturally appropriate to clients.

1. The organisation provides services that recognise and respect clients' ethnic, cultural and spiritual values and beliefs.

   1.1 The organisation provides services which meet the specific needs of Maori.
   1.2 The organisation provides services that meet the specific needs of Pacific peoples.

2. The organisation consults with, and where appropriate makes referrals to and negotiates protocols with, Maori, Pacific peoples and other cultural and specific interest services.

## Evidence

- Interview with two Counsellors and one Support Worker
- Review of the Quality Improvement Policy and Plan

## Exceptions

Based on the evidence provided for this review, no exceptions were identified.

## Outcome

Standard met

## SSAS Standard: Staffing (L2)

The organisation has the staffing capability and capacity to deliver services safely.

1. The organisation's staffing and staff relations policy and procedures comply with the relevant legislation.
2. The organisation includes in its definition of staff anyone the organisation relies on to deliver its services. This includes caregivers, volunteers and contractors, as well as paid staff members.
3. All staff have a written agreement of service.
4. The organisation uses a clear, transparent and open process for recruiting and vetting suitable staff including members of the organisation's governance body. Vetting of staff is to include, but is not limited to, a New Zealand police vet.
5. The organisation will follow a robust decision-making process in responding to the results of vetting, including safety checking.

   5.1 The organisation effectively manages any staff with a conviction, including members of governance.

   5.2 Unless a core worker exemption is held, an organisation does not employ any core children's worker who has a conviction for a specified offence under schedule two of the Vulnerable Children Act 2014.
6. The organisation will complete police checks, and any other relevant vetting for all staff at least every three years.
7. The organisation has sufficient, qualified and competent staff to deliver its services.
8. The organisation provides adequate induction, training, professional development and support for all staff.
9. The organisation uses an effective performance management system for all staff.

## Evidence

- Interview with two Counsellors and one Support Worker
- Review of Dispute Resolution Procedure
- Review of
- Review of five staff files
- Reviewed two staff work reports
- Review of Collective Annual General Meeting Minutes February 2018 and Collective Minutes for January 2019

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 6 | Repeat vetting was not completed for a staff member who has been employed for more than 3 years, this has now been initiated but at the time of this report being written the result had not yet been provided to the assessor. | Required Action |

## Outcome

Standard partially met

## SSAS Standard: Health and safety (L2)

The organisation ensures clients, staff and visitors are protected from risk.

1. The organisation ensures its place of work, and any place of work it uses or relies on for service delivery, comply with all legal and regulatory requirements.
2. The organisation will, as reasonably practicable, provide and maintain a working environment for its workers and members of the public that is safe and without risk to health.
3. If applicable, the organisation ensures the safety of any children being supervised in the place of work while their parents or caregivers receive services.
4. The organisation has safety and emergency plans for the evacuation of its place of work and any other place of work it uses for service delivery.
5. The organisation responds effectively to adverse events in the place of work.
6. The organisation has a business continuity and disaster recovery plan in place.
7. The organisation ensures that where an intervention, discipline or control is required or used, staff use appropriate methods that protect the physical and emotional safety of clients.
8. The organisation reflects continuous quality improvement principles in identifying and managing risk.

## Evidence

- Interview with two Counsellors/Health and Safety Officer and one Support Worker
- Review of Health and Safety Policy
- Sighted the Health and Safety folder, Hazard Identification form, Hazard Register, Injury and Incident Register, Health and Safety Checklist report template, injury and incident form
- Review of Job Description for the Health and Safety Officer
- Review of 3 Critical Incident forms
- Review of site security
- Completed site inspection

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | A review of the Health and Safety policy identified the policy is written to meet the outdated requirements of the Health and Safety in Employment Act 1992 and the Amendments in 2002. | Required Action |

## Outcome

Standard partially met

## SSAS Standard: Governance and management structure and systems (L2)

The organisation has a clearly defined and effective governance and management structure and systems.

1. The organisation has a defined and current legal status.
2. The organisation has an appropriate and clearly defined governance and management structure, the written record of which shows authorities, delegations, responsibilities and accountabilities.
3. The organisation is governed and managed by people with appropriate skills, qualifications and personal attributes.
4. The organisation has a process for identifying and managing perceived, actual or potential conflicts of interest, including between governance and management roles.
5. The organisation's management systems, policies and procedures are consistent with:

   5.1 relevant legislation
   5.2 its legal status, constitution, rules, charter or Act of Parliament
   5.3 the aims, philosophy and scope of its activities
   5.4 its management structure
   5.5 contractual obligations.
6. The organisation collects, records, stores and uses information in keeping with the relevant legislation.

## Evidence

- Interview with two Counsellors and one Support Worker/Financial Administrator
- Review of Governance and Management Structure Policy
- Review of Quality Improvement Policy Plan
- Review of Procedure for Conflict Resolution within a Collective
- Review of the Charities Services Register
- Review of Natural Disaster Policy

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 2 | The assessor spent time at this review talking with members of the collective to gain an understanding of how the organisation operates under a collective. Although generally governance would hold a different level of responsibility than the staff carrying out the day to day tasks in the case of this collective the roles are generally shared. Many of the collective members held dual roles including management associated tasks, operational delivery and governance. This does mean that every member of the collective takes responsibility for the policies and procedures, the service delivery and service quality and ensures those recruited into paid or volunteer roles have the right skills and attributes to participate in this type of work environment. Most paid members of the collective also give volunteer hours to the organisation to ensure those in need have 24 hour seven day a week access to crisis services. | Strength |

## Outcome

Standard met



# SSAS Standard: Financial management and systems (L2)

The organisation is financially viable and manages its finances competently.

1. The organisation is financially viable.
2. The organisation has an effective financial management system appropriate to the size and complexity of the organisation.
3. The organisation undertakes forward financial planning to show that it will remain financially viable.
4. The organisation has adequate insurance cover for the size and complexity of the organisation.
5. The organisation has arrangements for the regular independent audit, or in some cases review, of financial accounts.

## Evidence

- Interview with the Financial Administrator
- Review of Financial Policy
- Review of Rape Crisis (Dunedin) Inc – Performance Report for year ended 30 June 2018
- Review of Conflict Resolution Procedure
- Review of Annual Return summaries for year end June 2017 and June 2018
- Review letter (email) of extension of Insurance policy from Insurance Broker

## Exceptions

Based on the evidence provided for this review, no exceptions were identified.

## Outcome

Standard met

## SSAS Standard: Resolution of complaints related to service provision (L2)

The organisation uses an effective process to resolve complaints about service provision.

1. The organisation has a process for receiving, considering and resolving complaints that is soundly based in law and is consistent with the principles of natural justice, and ensures the support and safety of the complainant throughout the process.
2. The organisation ensures its clients and staff are aware of the complaints process.
3. The organisation seeks to resolve complaints effectively and makes improvements to the service as a result.

   3.1 The organisation must record the application of the complaints process and the resolution achieved.

   3.2 The organisation will provide evidence it has made appropriate improvements based on the analysis of complaints received.

## Evidence

- Interview with two Counsellors and one Support Worker
- Review of Complaints procedure
- Review of Quality Improvement Policy and Plan
- Sighted the premises display of information

## Exceptions

Based on the evidence provided for this review, no exceptions were identified.

## Outcome

Standard met

## SSAS Standard: Quality improvement (L2)

The organisation aims for excellence and manages the quality and risk of services.

1. The organisation regularly monitors:

   1.1 the organisation's individual policies and procedures
   1.2 its systems as a whole
   1.3 the performance of the organisation
   1.4 client outcomes.

2. The organisation uses a process to analyse monitoring and performance data for the purpose of improvement.

3. The organisation makes appropriate improvements, including risk mitigation, based on the analysis of this monitoring.

### Evidence

- Interview with two counsellors and one support worker
- Review of Quality Improvement Policy and Plan
- Review of Risk Management Policy
- Review of Natural Disaster Policy

### Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | On reviewing policies and procedures it was identified that some of the policy review dates have passed and therefore a review of the policy is now overdue. | Recommendation |

### Outcome

Standard met

## SSAS Standard: Client services and programmes (L2)

The organisation provides client services and/or programmes that meet clients' assessed needs, reflect desired outcomes and goals, and are planned, co-ordinated and reviewed.

1. The organisation collects appropriate information and ensures the needs of the client match the criteria for service.

2. The organisation completes a comprehensive and timely assessment.

   2.1 The organisation ensures it has necessary consents.

3. The organisation develops timely, effective plans for all client services and programmes:

   3.1 plans meet the needs of the client and the objectives of the service or programme

3.2 plans identify and mitigate safety risk to clients and others
3.3 where appropriate, plans include client's family and others

3.4 the plan clearly states the client's goals, and services used to help the client achieve their goals

3.5 plans are adequately resourced

3.6 the organisation completes regular, formal, recorded reviews of progress against the plan and outcomes achieved.

4. Conclusion of services to clients is planned and prepared for.

4.1 Safety risk of clients transitioning from the service are considered and managed.

5. The organisation ensures that client files and programme records are sufficient and document each stage of service provision.

## Evidence

- Interview with two Counsellors and one Support Worker
- Observation of the organisation in operation
- Review of Quality Improvement Policy and Plan
- Review of four client files with the Counsellor
- Presentation on the new client management system about to be implemented

## Exceptions

Based on the evidence provided for this review, no exceptions were identified.

## Outcome

Standard met

New Zealand Government

**Provider Legal Name:**
Rape Crisis (Dunedin) Incorporated

**Site Visit:** 12 April 2022

**Completed Date:** 4 August 2022

**NZBN Number:**
9429042815297

**RDA Number:**
11251

**Assessment Number:**
111138

## EXECUTIVE SUMMARY

Rape Crisis (Dunedin) Incorporated, has been assessed as partially meeting the standards for accreditation. Ten Level 2 Social Sector Accreditation Standards were assessed. One standard was met, and nine standards were partially met.

| SSAS Standards | Outcome | SSAS Standards | Outcome |
|---|---|---|---|
| Client-centred services (L2) | Standard partially met | Governance and management structure and systems (L2) | Standard partially met |
| Community wellbeing (L2) | Standard partially met | Financial management and systems (L2) | Standard partially met |
| Cultural competence (L2) | Standard met | Resolution of complaints related to service provision (L2) | Standard partially met |
| Staffing (L2) | Standard partially met | Quality improvement (L2) | Standard partially met |
| Health and safety (L2) | Standard partially met | Client services and programmes (L2) | Standard partially met |



## Corrective action plan

### Critical actions

No critical actions have been identified during the assessment.

### Required actions

| *Standard* | *Criteria* | *Action* | *Due by* |
|---|---|---|---|
| Client-centred services (L2) | 1 | To demonstrate improved commitment to the promotion of client centred services. This could be demonstrated by an improved work culture. | next review |
| Community wellbeing (L2) | 1 | Update the Paramountcy process to include entering a report of concern in the report of concern register and obtaining an | next review |

| | | | |
|---|---|---|---|
| | | acknowledgement of receipt from Oranga Tamariki. | |
| Staffing (L2) | 4 | Produce evidence of the forms of identification for Committee members. Provide evidence of the police vetting results for the Committee member who did not have evidence of police vetting. Provide evidence of the forms of identification and police vetting results for the recently appointed new admin staff member. Provide evidence of police vetting completed under Section 19 of the Clean Slate Act 2004 for all children's workers. All staff who are children's workers must be safety checked as required by the Children's Act 2014, at the time of employment. Background and child safety checks policies and procedures will be updated to identify positions defined as children's worker and core worker under the Children's Act 2014. | next review |
| Staffing (L2) | 5 | Provide evidence of risk assessments for all children's workers, confirming all safety checks have been completed and the person is considered safe to work with children. | next review |
| Staffing (L2) | 8 | Employment records must include evidence that new staff complete induction training. Employment records must include evidence of current supervision contacts (for relevant staff). | next review |
| Staffing (L2) | 9 | Employment records must include evidence of an effective performance management system. | next review |
| Health and safety (L2) | 2 | Develop a process for disciplinary action taken against a management committee member or for addressing interpersonal conflict or employment related concerns in disciplinary action and grievances and disputes policies and procedures.The Management Committee must ensure that all adverse events/behaviours that are experienced by all staff (which includes Committee Members) are appropriately documented. The organisation will demonstrate, as is reasonably practicable, that it is meeting its obligations and providing a working environment that is safe and without risk to health. This will involve identifying how it will address the concerns identified by staff and former staff about the negative work culture, feeling unsafe, targeted and bullied. | next review |
| Health and safety (L2) | 5 | All adverse events/behaviours that are experienced by all staff (which includes Committee Members) must be appropriately documented. | next review |
| Governance and management structure and | 1 | Provide evidence of the legal advice obtained for the reviewed constitution and evidence if the finalised constitution has incorporated this advice or outlines why it has not been adopted. | next review |

| | | | |
|---|---|---|---|
| systems (L2) | | | |
| Governance and management structure and systems (L2) | 2 | Provide evidence of a current organisational strategic plan. Provide evidence of improved and appropriate Management Committee minute keeping. The Management Committee must demonstrate that it is adhering to its Delegation policies and procedures, including evidence of the written records of delegations made to Committee members and limitations where conflict of interests are identified. | next review |
| Governance and management structure and systems (L2) | 3 | Develop role descriptions for all Management Committee members. Evidence of the skills, qualifications and personal attributes of all Management Committee members must be documented. | next review |
| Governance and management structure and systems (L2) | 4 | The Management Committee must confirm and demonstrate how it will manage the existing conflict of interest between two Members. This will include, but is not limited to, the application of the Delegations policies and procedures. | next review |
| Governance and management structure and systems (L2) | 5 | The Management Committee must operate according to its existing Rules, including observation of the meeting quorum. | next review |
| Governance and management structure and systems (L2) | 6 | Provide evidence of a filing system to identify and access Sharepoint organisational documents stored in 2021 has been completed. Update information safeguards policies and procedures to demonstrate user accounts, passwords and system access will be regularly reviewed. Provide evidence staff has received training on the organisation's privacy policies and procedures. Provide written procedures on how the Management Commitee will manage privacy requirements and Committee member's access to employment information that complies with the Privacy Act 2020. | next review |
| Financial management and systems (L2) | 2 | Financial delegations and responsibilities will be evidenced in the organisation's rules, delegations and/or financial controls policies and procedures. Financial policy and procedure online documents need to be checked to ensure the" links" connect to the correct documents. | next review |
| Resolution of complaints related to service provision (L2) | 1 | Provide evidence of how the Management Committee will enact a complaints process for receiving, considering and resolving complaints that is soundly based in law and is consistent with the principles of natural justice, and ensures the safety of the complainant throughout the process. This will also address the concerns associated with the conflict of interest between Committee Members. | next review |

| | | | |
|---|---|---|---|
| Resolution of complaints related to service provision (L2) | 2 | Feedback and complaints policies and procedures will evidence how the organisation will undertake an independent investigation if required and specify timeframes throughout the complaints process. | next review |
| Resolution of complaints related to service provision (L2) | 3 | Records of all complaints and actions taken, including a register of complaints, must be maintained. The Management Committee must demonstrate that it seeks to resolve complaints effectively and makes improvements as a result. | next review |
| Quality improvement (L2) | 1 | Check the " links" in Policy Place documents to ensure these connect to the correct document. Develop and implement procedures for local organisational procedures not identified in the Policy Place documents. Identify in organisational documents which position(s) is responsible for updating organisational policies and procedures. Identify in organisational documents and implement processes to monitor, analyse and respond to organszational data, such as staff turn over and the reasons for and level of sick leave. | next review |
| Quality improvement (L2) | 2 | Develop and implement a process to monitor and analyse the level of staff turnover, including exit interviews completed and the reasons identified for resignations. Implement a process to monitor and analyse the level of and reasons for staff sick leave. | next review |
| Quality improvement (L2) | 3 | Provide evidence of appropriate improvements, including risk mitigation, based on the analysis of staff turnover, exit interviews and the reasons for and level of sick leave. The hazard and risk management register will identify strategic risks as required by the organisation's Governance responsibilities policies and procedures. | next review |
| Client services and programmes (L2) | 2 | Client consent to participate in service will be recorded on the intake form. | next review |



## Strengths identified at review

Strengths were not applicable at this assessment.

## Recommendations

Client centred services (2)
It is recommended that the organisation formally identifies a process to ensure that clients with access limitations are not prevented from accessing 'on-site' services.

Health and safety (2)
It is recommended that Wellbeing policies and procedures are updated to include clients.

Financial management and systems (5)
It is recommended that the Management Committee check to ensure that their insurance has been renewed and that it is appropriate for the size and complexity of the organisation.

Governance and management structure and systems (2)
It is recommended that Management Committee Minutes identify members who are attending meetings remotely and record the technology used to attend.

Governance and management structure and systems (3)
It is recommended that the organisation advertise externally for new Management Committee members.

## Accreditation status

**Confirmation of Accreditation at Level 2 with required actions**

### The conditions of accreditation

Rape Crisis (Dunedin) Incorporated has been accredited by Te Kāhui Kāhu - Social Services Accreditation to deliver the following services:

- Couns. &/or prog. adult adoles. child perps Fam. Violence (Level 2)
- Couns. &/or prog. adult adoles. child victims fam. violence (Level 2)
- Gen. couns. incl. child adoles. relationship family therapy (Level 2)
- Family well-being services (Level 3)

### Action plan

The required actions in this report are to be addressed as soon as practicable. Completion of these actions will be assessed at the time of the next review. The next scheduled review is due within six months.

## OVERVIEW

This is a review assessment of Rape Crisis (Dunedin) Incorporated's accreditation status by Te Kāhui Kāhu - Social Services Accreditation.

The Rape Crisis (Dunedin) Incorporated website identifies that the organisation was formed in 1980, and that it is both an Incorporated Society and a Registered Charity (reference CC23913). In 2019 the organisation rebranded as Ōtepoti Collective Against Sexual Abuse (OCASA), although its legal title remained Rape Crisis (Dunedin) Incorporated. At the time of the site visit, the organisation was managed by a Management Committee consisting of two paid staff members (the Crisis and Operations Coordinators) and three volunteer members. The organisation has previously been a member of the National Collective of Rape Crisis.

The current assessment process started in May 2021 but was delayed because of resource issues in Te Kāhui Kāhu - Social Services Accreditation (Dunedin) and the impact of COVID-19. The initial process involved the desk-based review of the pre-assessment questionnaire (dated 24 June 2021) and supporting information provided by the Crisis Coordinator (at that time acting in the role).

On 3 February 2022 Te Kāhui Kāhu - Social Services Accreditation received an emailed document and several supporting documents *(*which had first been provided to Minister Davidson's office during 2021) which identified a range of concerns experienced and observed by staff in the organisation.

On 9 February 2022 Te Kāhui Kāhu - Social Services Accreditation received a separate email/documents, which advised that a group of current and recent former staff had concerns around the quality of organisational governance. Te Kāhui Kāhu - Social Services Accreditation determined that the separate concerns should be considered together and would be investigated as part of the current accreditation assessment.

The combined assessment process included the following steps:

- The desk-based review of the completed pre-assessment questionnaire (dated 24 June 2021) and supporting information
- 3 February 2022 Te Kāhui Kāhu - Social Services Accreditation received written concerns about the organisation from current staff
- 9 February 2022 Te Kāhui Kāhu - Social Services Accreditation received further written concerns about the organisation from current and former staff
- On 8 March 2022 Te Kāhui Kāhu - Social Services Accreditation advised the organisation of those concerns which appeared to breach the Social Sector Accreditation Standards (details set out below)
- On 1 April 2022 the organisation's Management Committee emailed their response to Te Kāhui Kāhu - Social Services Accreditation letter (of 8 March 2022)
- On 12 and 13 April 2022 an Assessor and a Senior Assessor completed the site visit at the organisation
- The Assessors met with the Crisis Coordinator, the Operations Coordinator, and two Committee members
- The Assessors met with four current staff who deliver client services (individual staff meetings) and the Finance administrator
- The Assessors met remotely with three former staff
- During the site visit the Assessors reviewed information held on site, including employment records, health and safety information and financial information
- On 2 May 2022 an Assessor met remotely with the Secretary of the Management Committee member based in Invercargill.



**Complaints**

The concerns from current and former staff received by Te Kāhui Kāhu - Social Services Accreditation in February 2022 refer to an ill-defined organisational structure, inadequate employment practices, and poor leadership resulting in what was described to Social Services Accreditation as a 'toxic' workplace culture leading to an organisational inability to fulfil its role.

The redacted documents from both complaints identify information provided by several staff and former staff, some of whom were also Management Committee members, and who were employed at different periods and in different positions. These documents identified alleged behaviour, incidents and procedures which had been personally experienced and/or witnessed in the workplace. The common adjective used to describe the alleged behaviour was "bullying".

The information received on 9 February 2022 identified two Management Committee members as being the alleged primary instigators of the behaviour and responsible for many of the examples of poor management. At the site visit it was confirmed that this conflict had been declared and recorded as a conflict of interest in the Conflict of interest register.

The following is a summary of the alleged concerns, sent to the organisation on 8 March 2022, where it was identified that the organisation may not have been meeting the Level 2 Social Sector Accreditation Standards:

Staffing standard

- Employment procedures have not complied with relevant legislation, for example some staff were not paid, and were not given adequate advice that they would not be paid despite working and submitting work hours and, an agreement to let an employee increase their hours was not adhered to, and an agreement to reduce an employee's hours was later altered without appropriate grounds (criteria 1)
- Staff recruitment processes have not followed a transparent and open process, with appropriate vetting completed (criteria 4)
- Staff advised that there was a lack of support for staff including access to the Employee Assistance Programme and external supervision (criteria 8)

Health and safety standard

- Inadequate worker engagement and participation in health and safety matters, for example the decision process relating to COVID-19 procedures, and claims of a workplace culture that has had negative impacts on health and wellbeing and the organisation's response to events that have had an emotional impact on staff (criteria 2)
- The organisation has not recorded all adverse events, responded openly and transparently, or taken action to prevent issues from reoccurring, for example the number of staff resignations citing employment issues, a bullying culture and the negative impact on staff health and wellbeing (criteria 5).

Governance and management structure and systems standard

- The organisation does not have an appropriate and clearly defined governance and management structure, does not maintain records which show authorities, delegations, responsibilities, and accountabilities, for example maintenance of records of membership of the Society and the process for appointment to, the responsibilities and records of the Management Committee (criteria 2)
- The people responsible for governance and management do not have the appropriate skills, qualifications, and personal attributes, demonstrated from the nature and number of concerns identified by staff over time (criteria 3)
- The organisation does not have a process for identifying and managing perceived, actual, or potential conflicts of interest, including between governance and management roles, for example relationships that exist outside of the workplace that may be perceived as potential conflicts of interest (criteria 4)
- The organisation has staff who do not understand privacy requirements, for example discussing human resources (HR) issues in the office, and concerns about privacy breaches. (criteria 6).

Resolution of complaints related to service provision standard

- Staff have not felt safe and have felt targeted from raising concerns (criteria 1)
- Complaints have not been properly recorded, resolved effectively and appropriate improvements have not been made. (criteria 3)

On 1 April 2022, Te Kāhui Kāhu - Social Services Accreditation received an email response made on behalf of the Management Committee. The email says (in part) that:

- Over the past two to three years the organisation has undergone a period of change, moving from a 'collective' style structure, supported largely by volunteers, to a professional, improved service and organisation with a more conventional model of governance
- It acknowledged the process involved trial and error
- It identified that changes could not occur overnight, and that some changes were met with resistance from an ideological point of view, and
- We believe the change process is in its final stages, which includes finalising the updated constitution, ensuring the Committee is more representative of local community, creates boundaries in organisational decision making and that the current system provides more stability and more accountability.

While Te Kāhui Kāhu - Social Services Accreditation has not been provided with evidence to substantiate the Management Committee's claims about the state of the organisation and services prior to the change process it does not discount that improvements and changes were needed. Te Kāhui Kāhu - Social Services Accreditation also acknowledges the well documented difficulties in implementing organisation change, including addressing staff/organisational resistance. It is also accepted that organisational change takes time and may involve trial and error.

s9(2)(a), s9(2)(ba)(i)



During the site visit on 12-13 April 2022 a Management Committee member advised that:

- the Committee cannot be held accountable for issues if staff did not complain and did not adhere to the complaint process, and

- staff were advised of the complaint process on, at least two occasions (evidenced in emails provided dated 6 November 2020 and again on 4 February 2022)

The Assessors have taken note of these points from the Management Committee, however more contextual information has been identified during the assessment. s9(2)(a), s9(2)(ba)(i) In addition, an effective complaints process - and organisations that are genuinely willing to engage in the process - will be open to and willing to accept information in any format. There is evidence that staff identified concerns to the Management Committee, in staff resignations, exit interviews and indirectly through the uptake of sick leave. Management Committee Minutes also refer to staff resignations, sick leave and some instances of alleged bullying.

Te Kāhui Kāhu - Social Services Accreditation is satisfied on the evidence available that the Management Committee was aware of claims from current and former staff about the workplace culture and some Committee Members' alleged behaviours and failed to adequately investigate or address these.

This report finds there are a number of contributing factors involved in this failure to address the internal issues in the organisation, the most apparent being the inherent conflict of interest s9(2)(a) In addition to the Management Committee's failure to actively manage this conflict of interest when staff raised questions and concerns, there was no evidence provided during the assessment to demonstrate the organisation is managed and governed by people with appropriate management and governance skills. The organisation's policies and procedures also have no process for taking disciplinary action against a Management Committee member or to address interpersonal conflicts or for employment related concerns against a Management Committee member.



**Management Committee Concerns:**

This assessment and a review of Management Committee Meeting Minutes (February 2021 to March 2022) identified a number of areas where the Management Committee processes do not align with their Rules, do not reflect good practice, and do not meet these Standards. Examples include:

- There was no evidence provided of the Management Committee members' experience, skills and personal attributes recorded
- The Management Committee minutes identify frequent meetings where they did not have a quorum
- However, a decision dated 16 March 2021 to consider a request for discretionally leave was declined on the grounds there were not enough votes. The record of the meeting records two of the three Members present supported the request and the third member voted against it. The record of the meeting is signed by two Members, one of whom was not present at the meeting and the other who voted against the request.
- At least one current Management Committee member, identified during an interview, did not know the correct quorum for holding meetings

- s9(2)(a), s9(2)(ba)(i) [redacted]
- The 2021 AGM minutes (14 July 2021) were approved at the following Management Committee meeting held on 20 July 2021
- Documentation in Minutes of financial monitoring processes was sparse
- Minutes consistently include a section Interests Register, but information was not recorded. (It is acknowledged that there were occasions when conflicts of interest were recorded in the body of minutes, but these did not always identify the reason for the conflict).
- s9(2)(a) [redacted]
- s9(2)(a) [redacted]
- There was no evidence that delegations were documented as required by the organisation's policies and procedures
- Minutes refer to event and actions but there is no evidence of a system to ensure actions were progressed and completed in a reasonable time frame, or grounds for actions not being completed. For example, the rewrite of the Rules, the disaffiliation from the National Collective of Rape Crisis and holding regular General Committee meetings (Minutes 22 June 2021)
- s9(2)(a), s9(2)(ba)(i) [redacted]
- Some Committee members have fulfilled this role at the same time as being in paid staff roles. It is acknowledged this can be common in a collective structure, however if it is not well managed it has the potential for 'role-related' conflicts of interest
- Committee minutes include examples which suggest staffing issues and entitlements may not have been considered in a context of good faith and transparency, for example the request for discretionary leave and revising employment conditions to be based on "…our minimum requirements as an employer" (Minutes 21 December 2021, 16 March 2021, 25 May 2021)
- Management Committee record keeping has not always been robust, for example the Committee were unable to provide evidence to support some processes, including recommendations provided by the external contractor and evidence of delegations
- The current Management Committee appears to consist of three 'friends' of the organisation and two 'Counsellors' which does not meet the requirements of clause 6 (b) of their existing rules. These rules require that a "minimum of two thirds of the members of the Management Committee shall be Counsellors"

This review has established that the organisation is not meeting all the standards for accreditation. This review has also established some of the complaints made have been substantiated. Required actions have been identified which must be addressed and these are detailed in this report.

A further review will be completed in six months.

This is an Inter-Agency assessment.

## KEY FINDINGS

## SSAS Standard: Client-centred services (L2)

The organisation treats people with respect and delivers services in a manner that has regard for their dignity, privacy and independence.

1. The organisation promotes client-centred practice as central to its service development and delivery.

   1.1 The organisation involves its clients and stakeholders in planning, implementation, and evaluation at all levels of the service to ensure services are current and responsive.

2. The organisation provides services that are accessible to people with disability.
3. The organisation provides services that are free from any discrimination, coercion, harassment, and sexual, financial or other exploitation.
4. The organisation recognises and facilitates the right of people to advocacy and/or support persons of their choice.

### Evidence

- Interviewed the Crisis Coordinator, Operations Coordinator, current and former staff members, and a Committee member
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Misconduct or serious misconduct policies and procedures (November 2020)
- Reviewed Disability confidence policies and procedures (December 2021)
- Reviewed Vulnerable persons policies and procedures (March 2021)
- Reviewed Your voice matters evaluation form (undated)
- Reviewed Intake form - How to provide feedback (June 2021)
- Reviewed Strategic plan – building accessibility (March 2016)
- Site inspection for accessibility
- Reviewed organisation's website information (Confidentiality, Complaints, Rights and Privacy) (26 April 2022)

### Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | The information obtained during this assessment identifies high levels of staff turn-over and uptake of sick leave. The information also identifies ineffective management and governance systems have existed over a period of time. The complaint documents received by Te Kahui Kahu - Social Services Accreditation refer to current and former staff being concerned at the negative impact these matters had | Required Action |

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|---|---|---|
| | on the provision of client services. | |
| 2 | Client-centred services (2)<br>The organisation's website identifies that it is located on the first floor and that people can contact them if they need to talk about accessibility to their space. The building that does not have an elevator, it is understood that in the past the organisation has had access to space on the ground floor. | Recommendation |

## Outcome

Standard partially met

## SSAS Standard: Community wellbeing (L2)

The organisation provides services which reflect the principle that the welfare and interests of the child or young person are first and paramount and where the wellbeing of all is upheld.

1. The organisation provides services in a manner consistent with section 6 of the Oranga Tamariki Act 1989, where services reflect the principle that the welfare and interests of the child or young person are the first and paramount consideration.
2. The organisation has a process for dealing with allegations of abuse and situations that raise concerns about the safety of a client or associated community member.

   2.1 The process specifically includes guidelines on how the organisation makes referrals under section 15 of the Oranga Tamariki Act 1989.
3. The organisation promotes awareness of the unacceptability of abuse, ways in which abuse may be prevented, the need to report all cases of abuse and how to respond to all types of abuse. Abuse includes physical, emotional or sexual harm; ill-treatment; neglect or deprivation either passive or active.
4. The organisation promotes awareness of where a conflict between the needs of a client and others might arise, and uses a process to respond to such conflicts.
5. The organisation has a procedure to identify clients who may have limited ability to give informed consent. This procedure ensures that such clients are able to exercise the ability they have to the fullest extent possible.
6. When it is confirmed that a client has a limited ability to give informed consent, the organisation acts appropriately.
   For those organisations that must comply with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, this will mean following the principles of Right 7.

## Evidence

- Interviewed the Crisis Coordinator
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Vulnerable persons policies and procedures (March 2021)
- Reviewed Survivor-centred services (October 2021)
- Reviewed Code of conduct policies and procedures (March 2021)
- Reviewed Informed consent policies and procedures (February 2022)

- Reviewed Paramountcy process (undated)
- Sighted Survivor Support Team process folder
- Sighted Paramountcy process (4 June 2021)
- Sighted Child protection register
- Sighted Report of concern register
- Sighted Report of concern and acknowledgement of receipt from Oranga Tamariki (29 July 2020)
- Sighted Staff training register
- Sighted Staff child protection records (March to July 2021)
- Sighted one Education programme report (1 July 2020 to 30 June 2021).

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | The paramountcy process does not align with the organisation's practice to include entering a report of concern in the report of concern register or obtaining an acknowledgement of receipt from Oranga Tamariki. | Required Action |

## Outcome

Standard partially met

## SSAS Standard: Cultural competence (L2)

The organisation provides services that are culturally appropriate to clients.

1. The organisation provides services that recognise and respect clients' ethnic, cultural and spiritual values and beliefs.

   1.1 The organisation provides services which meet the specific needs of Maori.
   1.2 The organisation provides services that meet the specific needs of Pacific peoples.

2. The organisation consults with, and where appropriate makes referrals to and negotiates protocols with, Maori, Pacific peoples and other cultural and specific interest services.

## Evidence

- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Pasifika policies and procedures (February 2021)
- Reviewed Te Tiriti o Waitangi policies and procedures (July 2021)
- Reviewed Māori partnership and bicultural business plan (12 January 2021)
- Reviewed Culture of OCASA document (12 January 2021)
- Reviewed Equity, diversity, and inclusion plan (12 January 2021)
- Reviewed Celebrating identity, language, and culture course record (17 to 18 June 2021)
- Reviewed Intake form – demographics (June 2021)
- Reviewed Strategic plan – key objectives (2016)
- Visit to site on 12 and 13 April 2022

- Meetings with staff and Committee members
- Reviewed a sample of Committee minutes (March 2021 to March 2022).

## Exceptions

Based on the evidence provided for this review, no exceptions were identified.

## Outcome

Standard met

## SSAS Standard: Staffing (L2)

The organisation has the staffing capability and capacity to deliver services safely.

1. The organisation's staffing and staff relations policy and procedures comply with the relevant legislation.
2. The organisation includes in its definition of staff anyone the organisation relies on to deliver its services. This includes caregivers, volunteers and contractors, as well as paid staff members.
3. All staff have a written agreement of service.
4. The organisation uses a clear, transparent and open process for recruiting and vetting suitable staff including members of the organisation's governance body. Vetting of staff is to include, but is not limited to, a New Zealand police vet.
5. The organisation will follow a robust decision-making process in responding to the results of vetting, including safety checking.

   5.1 The organisation effectively manages any staff with a conviction, including members of governance.

   5.2 Unless a core worker exemption is held, an organisation does not employ any core children's worker who has a conviction for a specified offence under schedule two of the Children's Act 2014.
6. The organisation will complete police checks, and any other relevant vetting for all staff at least every three years.
7. The organisation has sufficient, qualified and competent staff to deliver its services.
8. The organisation provides adequate induction, training, professional development and support for all staff.
9. The organisation uses an effective performance management system for all staff.

## Evidence

- Interviewed the Crisis Coordinator, Operations Coordinator, current and former staff members
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Background and child safety checks policies and procedures (April 2021)
- Reviewed Children’s worker risk assessment/safety checklist
- Reviewed Misconduct policies and procedures (November 2020)

- Reviewed Misconduct or serious misconduct policies and procedures (November 2020)
- Reviewed Disciplinary action policies and procedures (November 2020)
- Reviewed Grievances and disputes policies and procedures (November 2020)
- Reviewed Professional development policies and procedures (November 2020)
- Reviewed Performance appraisal policies and procedures (January 2022)
- Reviewed Code of conduct policies and procedures (March 2021)
- Reviewed Responding to abuse allegations against staff members (March 2021)
- Reviewed Staff recruitment policy and procedures (17 February 2015)
- Reviewed six current and four former staff personnel records
- Confirmed access to and attendance at external Supervision, and availability of EAP
- Sighted Staff case consults (26 July 2021 to 9 February 2022)
- Sighted two Case management meeting minutes (2 and 9 March 2022)
- Reviewed a sample of Committee minutes (March 2021 to March 2022).

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 4 | The Management Committee was unable to provide evidence that it had established the identity for one Committee member and did not have evidence of a completed police vetting process. The organisation was unable to provide evidence that it had established the identity of a recently appointed staff member (who is not a children's worker) and police vetting results had not been received. Children's workers' police vetting has been completed as standard checks under Section 16 of the Clean Slate Act 2004 instead of the exception checks required for children's workers<br><br>The review of employment records identified examples of inconsistent procedures, areas where employment procedures did not meet these standards and/or align with good employment practises. For example:<br>At least one staff member was appointed without being formally interviewed, having referee checks completed, qualifications confirmed, police vetting completed, work history documented, and identification established;<br>Only one record included evidence of two acceptable forms of identification;<br>While some records recorded interviews had been completed, evidence of the process was not retained;<br>Two reference checks had not being completed for all staff;<br>Staff who are children's workers had not had all safety checks completed, as required under the Children's Act 2014 before they were employed.<br><br>Identification of positions defined as children's workers and core workers under the Children's Act 2014 were not evidenced in background and child | Required Action |

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|---|---|---|
| | safety checks policies and procedures. | |
| 5 | Risk assessments for children's workers have not been completed, as required under the Children's Act 2014 to confirm all other safety checks have been completed and that the person is considered safe to work with children and young people. | Required Action |
| 8 | The review of employment records failed to identify evidence of an acceptable induction process. Most records did not contain any evidence of induction training, some included an induction training plan, but these had not been completed.<br>The employment records reviewed did not include evidence of supervision contracts or agreements. | Required Action |
| 9 | Three of the employment records reviewed included evidence of performance appraisals, two completed in 2020 and one in 2019. | Required Action |

## Outcome

Standard partially met

## SSAS Standard: Health and safety (L2)

The organisation ensures clients, staff and visitors are protected from risk.

1. The organisation ensures its place of work, and any place of work it uses or relies on for service delivery, comply with all legal and regulatory requirements.
2. The organisation will, as reasonably practicable, provide and maintain a working environment for its workers and members of the public that is safe and without risk to health.
3. If applicable, the organisation ensures the safety of any children being supervised in the place of work while their parents or caregivers receive services.
4. The organisation has safety and emergency plans for the evacuation of its place of work and any other place of work it uses for service delivery.
5. The organisation responds effectively to adverse events in the place of work.
6. The organisation has a business continuity and disaster recovery plan in place.
7. The organisation ensures that where an intervention, discipline or control is required or used, staff use appropriate methods that protect the physical and emotional safety of clients.
8. The organisation reflects continuous quality improvement principles in identifying and managing risk.

## Evidence

- Interviewed the Crisis Coordinator, Operations Coordinator, current and former staff members and a Committee member
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Risk Management policies and procedures (August 2020)

- Reviewed Grievances and disputes policies and procedures (November 2020)
- Reviewed Misconduct policies and procedures (November 2020)
- Reviewed Misconduct or serious misconduct policies and procedures (November 2020)
- Reviewed Disciplinary action policies and procedures (November 2020)
- Reviewed Code of conduct policies and procedures (March 2021)
- Responding to abuse allegations against staff members (March 2021)
- Reviewed Wellbeing policies and procedures (April 2021)
- Reviewed Health and safety policies and procedures (June 2021)
- Reviewed Accident, injury, and incident template
- Reviewed one incident 22 June (year unrecorded)
- Reviewed COVID-19 information for clients (undated)
- Sighted Hazard and risk management register
- Sighted Health and safety incident register (30 September 2021 to 29 March 2022)
- Sighted three Incident records (17 January 2021 to 2 November 2021)
- Sighted two Case management meeting minutes (2 and 9 March 2022)
- Sighted four Staff health and safety check-in records (January 2020 to June 2021)
- Site inspection
- Sighted Building Warrant of Fitness expires 12 April 2023
- Sighted I-payroll leave taken report from July/August 2021
- Review of documents relating to Worksafe complaint about COVID-19 response, including Worksafe NZ email (27 April 2022)
- Reviewed a sample of Committee minutes (March 2021 to March 2022).

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 2 | Current and former staff members have stated that they experienced and witnessed behaviours and a work culture that adversely impacted on them. They also advise that the degree and prolonged nature of these experiences adversely impacted on their ability to provide quality services to clients and affected their health which resulted in some taking sick leave. A number of staff, including Committee Members have resigned citing the work culture and behaviours as the reasons. Management Committee minutes make reference to staff resignations, exit interviews and allegations of bullying. Some employment records include resignation letters, emails to the Committee and notes where staff have recorded their concerns about the workplace and culture.<br>The organisation is not currently providing a safe working environment for staff, and consequently also for clients.<br><br>There is no evidence of a process for taking disciplinary action against a Management Committee member or for addressing interpersonal conflict or employment related concerns against a Management Committee member in disciplinary action or grievances and disputes policies and procedures. | Required Action |

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|---|---|---|
| 2 | Health and safety (2)<br>Wellbeing policies and procedures relate to staff. There was no evidence clients are included in these policies and procedures. | Recommendation |
| 5 | Not all adverse events/behaviours have been appropriately documented. | Required Action |

## Outcome

Standard partially met

## SSAS Standard: Governance and management structure and systems (L2)

The organisation has a clearly defined and effective governance and management structure and systems.

1. The organisation has a defined and current legal status.
2. The organisation has an appropriate and clearly defined governance and management structure, the written record of which shows authorities, delegations, responsibilities and accountabilities.
3. The organisation is governed and managed by people with appropriate skills, qualifications and personal attributes.
4. The organisation has a process for identifying and managing perceived, actual or potential conflicts of interest, including between governance and management roles.
5. The organisation's management systems, policies and procedures are consistent with:

   5.1 relevant legislation
   5.2 its legal status, constitution, rules, charter or Act of Parliament
   5.3 the aims, philosophy and scope of its activities
   5.4 its management structure
   5.5 contractual obligations.
6. The organisation collects, records, stores and uses information in keeping with the relevant legislation.



## Evidence

- Interviewed Operations and Crisis Support Coordinators, and current Committee member
- Interviewed current and former staff members
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Remote working information security policies and procedures (March 2020)
- Reviewed Protection of privacy policies and procedures (October 2020)
- Reviewed Information sharing policies and procedures (October 2020)
- Reviewed Duty of care policies and procedures (October 2020)
- Reviewed Information safeguards policies and procedures (October 2020)
- Reviewed Safe disposal of information policies and procedures (October 2020)

- Reviewed Conflict of interest policies and procedures (August 2021)
- Reviewed Management committee recruitment (January 2022)
- Reviewed Management committee membership (January 2022)
- Reviewed Grievances and disputes policies and procedures (November 2020)
- Reviewed Misconduct policies and procedures (November 2020)
- Reviewed Misconduct or serious misconduct policies and procedures (November 2020)
- Reviewed Disciplinary action policies and procedures (November 2020)
- Reviewed Code of conduct policies and procedures (March 2021)
- Reviewed Responding to abuse allegations against staff members (March 2021)
- Reviewed Delegations policies and procedures (August 2021)
- Reviewed Client record keeping policies and procedures (February 2022)
- New Zealand Business Number website search (1 March 2022); NZBN 9429042815297, registered 1 February 1982
- Incorporated Society register search (1 March 2022); Incorporation number 226133, registered 1 February 1982
- Charities Services register search (1 March 2022); reference cc23913, registered 5 May 2008
- Reviewed organisation's Rules
- Reviewed Rape Crisis (Dunedin) Incorporated documented (undated) – draft revised Constitution/Rules
- Reviewed Strategic plan March 2016-2021
- Reviewed OCASA Strategy – follow up session document/notes (29 January 2021)
- Sighted Management Committee strategy hui minutes (13 November 2021)
- Reviewed Performance report year ended 30 June 2020
- Reviewed Management Committee meeting minutes March 2021 to 29 March 2022)
- Sighted Conflict of interest register (March 2021-2022)
- Sighted Register of members (November 2021) revised (16 February 2022)
- Reviewed organisations website information (Confidentiality, Complaints, Rights and Privacy) (26 April 2022)
- Reviewed emails advising staff of complaints processes (6 November 2020 and 4 February 2020)
- Reviewed a sample of Committee Minutes from March 2021 to March 2022
- Reviewed Management Committee's email (1 April 2022) response to complaints.

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | In May 2021 a new Committee member (with a conflict of interest) was appointed. Committee minutes refer to his undertaking a rewrite of the constitution and consulting a legal professional about the draft document. The draft document provided at the site visit (12 April 2022) did not track changes, the changes identified appeared to be minimal, and did not include the level of detail observed in the NZ Companies Office website (Constitution Building Tool). When asked for evidence that the Committee had obtained legal advice on the draft document, as referred to in minutes, Te Kāhui Kāhu – Social Services Accreditation was advised that this would be sought after the Committee had ratified the updated document. | Required Action |

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| 2 | As identified in the Overview of this report, the contents of Committee Minutes did not reflect good management/governance procedures and knowledge. At the site visit two Committee members advised they had considered changing the minutes for some time.<br>The strategic plan March 2016-2021 has not been renewed. Minutes for the Strategic Hui (13 November 2021) identify action points, but no evidence was provided on process/completion of the action points.<br>The organisation's Delegations policies and procedures require (in part) that a record of delegations must be kept, updated, and made available to staff; and that no delegated person may exercise delegations if they have or may be perceived as having some conflict of interest.<br>The organisation was unable to provide evidence of delegations given to Committee members.<br>Management Committee Minutes record the Committee Member (conflict of interest) has been repeatedly involved in a range of operational matters, including employment issues.<br>The Management Committee is not adhering to the Delegations policies and procedures. | Required Action |
| 2 | Governance and management structure and systems (2)<br>One member of the Committee resides outside of Dunedin and attends Committee meetings 'remotely'. Because of COVID, it is understood that some Committee meetings will have been completed 'remotely'. Committee minutes do not identify members or guests who are not physically present but are attending the meeting remotely. | Recommendation |
| 3 | Evidence of role descriptions for the Treasurer and Secretary was provided at the site visit. There was no evidence of role descriptions for the remaining Management Committee Members.<br>This assessment report has identified a number of issues and processes which indicate the need to strengthen management and governance.<br>The organisation did not hold information on Management Committee members skills, qualifications, and experience in governance and management. | Required Action |
| 3 | Governance and management structure and systems (3)<br>The Management Committee Strategic Hui (13 November 2021) records that it was suggested the organisation advertise externally for additional Committee Members. The two Committee members with a conflict of interest are recorded as not supporting this. | Recommendation |

| | | |
|---|---|---|
| 4 | The Management Committee includes two members who acknowledge a conflict of interest, and which is documented in the Conflicts of interest register.<br><br>This conflict of interest between the two Committee member features in the complaints made to Te Kāhui Kāhu.<br>This report has identified examples where the conflict of interest has not been appropriately managed (for example the Delegations policies and procedures).<br>As identified elsewhere, there have been times when the Management Committee has met without the required quorum and the Committee has indicated that it is considering reducing the quorum from five to three. A committee consisting of three members, where two have a declared conflict of interest could prove problematic. | Required Action |
| 5 | The organisation's Rules identify that the quorum for Management Committee meetings is five members. Committee minutes record that meetings were frequently held when they did not have a quorum. One Committee member was unaware of the required quorum, believing it to be two-thirds of members. | Required Action |
| 6 | Management Committee minutes record that Committee members decided that, because of the workload involved, they would take turns ('pass the baton') to share the workload until another manager was appointed. The minutes also record that access to employment information would be restricted to the week each member held the baton. While the Committee was correct to consider how they could comply with privacy requirements, the decision does not achieve this, nor support efficient employment processes.<br>Some Sharepoint organisational documents were unable to be located during the assessment. A filing system to identify and access Sharepoint documents stored in 2021 is under development. There was no evidence of user accounts, passwords and system access being regularly reviewed in information safeguards policies and procedures. Staff has not received training on the organisation's privacy policies and procedures. Several examples were identified where employment files did not contain required information (including exit interviews). It is acknowledged that the Operations Coordinator providing this information during the site visit is a relatively new employee. | Required Action |

## Outcome

Standard partially met

## SSAS Standard: Financial management and systems (L2)

The organisation is financially viable and manages its finances competently.

1. The organisation is financially viable.
2. The organisation has an effective financial management system appropriate to the size and complexity of the organisation.
3. The organisation undertakes forward financial planning to show that it will remain financially viable.
4. The organisation has adequate insurance cover for the size and complexity of the organisation.
5. The organisation has arrangements for the regular independent audit, or in some cases review, of financial accounts.



### Evidence

- Interviews with Crisis Coordinator, Operations Coordinator and Financial administrator
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Financial controls policies and procedures (July 2021)
- Reviewed Delegations policies and procedures (August 2021)
- Reviewed Financial and property management (January 2022)
- Reviewed Performance report year ended 30 June 2020
- Reviewed Independent Auditor's report (7 May 2021)
- Reviewed Audit Professional's letter (5 April 2022) to Management Committee
- Reviewed Performance Report for the year ending 30 June 2021
- Reviewed Balance sheet (24 June 2021)
- Reviewed Operating budget (2020-2021)
- Reviewed Budget variance (26 February to 24 March 2021)
- Sighted Bank statement (26 February to 24 March 2021)
- Sighted two bank statement summaries of accounts (24 March to 22 April 2021 and 23 April to 28 May 2021)
- Reviewed Crombie Lockwood insurance renewal statement (expires 29 April 2021): Association liability package and cyber
- Reviewed Rothbury Insurance document (cover form 1 August 2021 to 1 August 2022)
- Site visit completed on 12 and 13 April 2022
- Sighted GST summary of payments (1 July 2021 to 31 December 2021)
- Sighted PAYE payment (due September 2021 to 31 December 2021; nil in arrears)
- Sighted Budget variance 1 July 2021 to 1 January 2022
- Reviewed Budget (July 2021 to June 2022)
- Sighted debit card statement (to 12 April 2022)
- Sighted examples of invoice reconciliation processes
- Sighted BNZ statements Expense account, General account, Grant's account (28 February 2022 to 31 March 2022)
- Sighted I-payroll leave taken report (July-August 2021)
- Reviewed a sample of Committee Minutes from March 2021 to March 2022

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 2 | Financial policies and procedures did not include specific financial delegations and responsibilities. Financial policy and procedures included links to other related financial documents. However, several links did not connect to the named document. (This issue was also identified in other policy and procedure documents)<br>Management Committee Minutes frequently identified inconsistent and insufficient information to evidence that the Committee was appropriately reviewing financial processes and information. | Required Action |
| 4 | Financial management and systems (4)<br>Insurance with Crombie and Lockwood was due to expire on 24 April 2022 and details of the new insurance policies was not yet available. The Operations Coordinator advised the organisation was in the process of obtaining new insurance. | Recommendation |

## Outcome

Standard partially met

## SSAS Standard: Resolution of complaints related to service provision (L2)

The organisation uses an effective process to resolve complaints about service provision.

1. The organisation has a process for receiving, considering and resolving complaints that is soundly based in law and is consistent with the principles of natural justice, and ensures the support and safety of the complainant throughout the process.
2. The organisation ensures its clients and staff are aware of the complaints process.
3. The organisation seeks to resolve complaints effectively and makes improvements to the service as a result.

   3.1 The organisation must record the application of the complaints process and the resolution achieved.

   3.2 The organisation will provide evidence it has made appropriate improvements based on the analysis of complaints received.

## Evidence

- Interviewed the Crisis Coordinator, Operations Coordinator, Committee members
- Interviews with existing staff
- Remote meetings with former staff
- Reviewed pre-assessment questionnaire (dated 24 June 2021)

- Reviewed Governance responsibilities policies and procedures (January 2022) - Risk Management section
- Reviewed Responding to abuse allegations against staff members (March 2021)
- Reviewed organisations website information (Confidentiality, Complaints, Rights and Privacy) (26 April 2022)
- Reviewed complaints information received by Te Kāhui Kāhu (3 and 9 February 2022)
- Reviewed a sample of Management Committee Minutes from March 2021 to March 2022
- Reviewed Management Committee's email (1 April 2022) response to the complaints
- Sighted new Check in document to be completed by individual staff and to be submitted to Management Committee from February 2022
- Reviewed timeline of complaints compiled by the Crisis Coordinator (undated)
- Reviewed emails provided by Crisis Coordinator that referred to complaints and the Complaints processes: 6 November 2020; 9 November 2020; 16 November 2020; 4 February 2021; 4 February 2021; 22 November 2021; 7 December 2021; 12 January 2022; 8 February 2022; 16 February 2022; 2 March 2022.

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | The concerns received by Te Kahui Kahu on 3 and 9 February 2022 identified staff's experiences with trying to raise concerns. In particular, staff identified that they felt targeted for raising concerns (and/or that they had observed this behaviour), and as a consequence they did not feel safe in the workplace.<br><br>During interviews with staff there was a uniform concern about being identified from information provided. This concern extended, although to a lesser degree, to some former staff.<br><br>An email (4 February 2021) from the Crisis Coordinator to the Collective appropriately advised of the Complaint process implemented to take into account the creation of the new Operations Manager role.<br><br>On 16 February 2022 the Committee Secretary emailed staff an amended process to address the appointment of the Operation's Coordinator and identified two Committee members delegated to receive and respond to complaints.<br><br>Issues with both these processes include:<br>• 9(2)(a)<br>• The position of Operations Manager was vacant for some months during 2021, and it is unclear what process applied<br>• 9(2)(a) advised that staff did not put concerns in writing or complain | Required Action |

| | | |
|---|---|---|
| | as they were scared. Staff also advised that they did not feel it would achieve anything as concerns eventually went to the Committee which was not impartial and was unduly influenced by one member<br>• 9(2)(a) [redacted]<br>• 9(2)(a) [redacted]<br><br>Although there is information to show that the Complaints process has been amended and a new Committee member involved in the Complaint process, these changes did not adequately address the reasons why staff felt unsafe and unable to follow the Complaints process. | |
| 2 | There was no evidence on how the organisation will undertake an independent investigation if required or specified timeframes throughout the complaints process in the Feedback and complaints policies and procedures. | Required Action |
| 3 | The pre-assessment questionnaire (24 June 2021) states no formal complaints had been received and that the Complaints policies and procedures had not been updated since the last assessment (May 2019)<br>Information obtained during this assessment process confirms that complaints were made, and that the Complaints process had been amended.<br>The organisation has not maintained adequate records of all complaints and actions taken, including a register of complaints.<br>As the organisation has failed to identify and record all complaints it has also failed to demonstrate that it has make appropriate improvements based on the analysis of complaints received. | Required Action |



## Outcome

Standard partially met

## SSAS Standard: Quality improvement (L2)

The organisation aims for excellence and manages the quality and risk of services.

1. The organisation regularly monitors:

    1.1 the organisation's individual policies and procedures

1.2 its systems as a whole
1.3 the performance of the organisation
1.4 client outcomes.

2. The organisation uses a process to analyse monitoring and performance data for the purpose of improvement.

3. The organisation makes appropriate improvements, including risk mitigation, based on the analysis of this monitoring.

## Evidence

- Interviewed the Crisis Coordinator, Operations Coordinator, Committee members
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Reviewed Governance responsibilities policies and procedures (January 2022) - Risk Management section
- Reviewed Quality assurance and improvement policies and procedures (January 2022)
- Sighted Staff case consults (26 July 2021 to 9 February 2022)
- Reviewed Accident, injury, and incident template
- Sighted Hazard and risk management register
- Sighted Health and safety incident register (30 September 2021 to 29 March 2022)
- Reviewed sample of Management Committee meeting minutes from March 2021 to March 2022
- Reviewed revised draft rules (undated)
- Reviewed Strategic plan (March 2016 - 2021)
- Reviewed OCASA Strategy – follow up session (29 January 2021)
- Sighted three Client files (crisis support, court support and counselling)
- Sighted one Education programme report (1 July 2020 to 30 June 2021
- Sighted I-payroll leave taken report from July/August 2021
- Reviewed pay system date (November 2020 to August 2021)
- Reviewed sample of bank statements (March 2021 to May 2021)
- Reviewed Monitoring reports (Partnering for Outcomes, Funding) 15 April 2021 and 17 February 2022.



## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 1 | In June 2021 the organisation agreed to use Policy Place policies and procedures. The review of the Policy Place policies and procedures used by the organisation identified two issues: that a significant number of 'links' included in the policies did not connect to the correct document, and; that the organisation had not put in place specific organisational procedures needed to supplement the generic Policy Place documents. | Required Action |
| 2 | From July 2021 the organisation had access to staffs' leave data via I-payroll.<br>At the site visit Management Committee members acknowledged that they were unable to identify staff turnover or the level and reasons for sick leave uptake. Current and former staff identified that the | Required Action |

| | | |
|---|---|---|
| | workplace culture and management were responsible for the level of staff sick leave and resignations. There was no evidence available that demonstrated that the Management Committee monitored and analysed this data. | |
| 3 | Refer to the required action in criteria 2 of this standard. There was no evidence available to demonstrate that the Committee makes appropriate improvements, including risk mitigation based on the analysis of monitoring.<br>The Hazard and risk management register does not identify strategic risks as required by the organisation's Governance responsibilities policies and procedures risk management section. | Required Action |

Outcome

Standard partially met

## SSAS Standard: Client services and programmes (L2)

The organisation provides client services and/or programmes that meet clients' assessed needs, reflect desired outcomes and goals, and are planned, co-ordinated and reviewed.

1. The organisation collects appropriate information and ensures the needs of the client match the criteria for service.
2. The organisation completes a comprehensive and timely assessment.

   2.1 The organisation ensures it has necessary consents.
3. The organisation develops timely, effective plans for all client services and programmes:

   3.1 plans meet the needs of the client and the objectives of the service or programme

   3.2 plans identify and mitigate safety risk to clients and others
   3.3 where appropriate, plans include client's family and others

   3.4 the plan clearly states the client's goals, and services used to help the client achieve their goals

   3.5 plans are adequately resourced

   3.6 the organisation completes regular, formal, recorded reviews of progress against the plan and outcomes achieved.
4. Conclusion of services to clients is planned and prepared for.

   4.1 Safety risk of clients transitioning from the service are considered and managed.
5. The organisation ensures that client files and programme records are sufficient and document each stage of service provision.

## Evidence

- Interviewed the Crisis Co-ordinator
- Reviewed pre-assessment questionnaire dated (24 June 2021)
- Sighted three Client files (crisis support, court support and counselling)
- Sighted one Education programme report (1 July 2020 to 30 June 2021)
- Reviewed Monitoring reports (Partnering for Outcomes, Funding) (15 April 2021 and 17 February 2022.)

## Exceptions

| *Criteria* | *Findings* | *Type of finding* |
|---|---|---|
| 2 | Client consent to participate in service was not recorded on the intake form. | Required Action |

## Outcome

Standard partially met