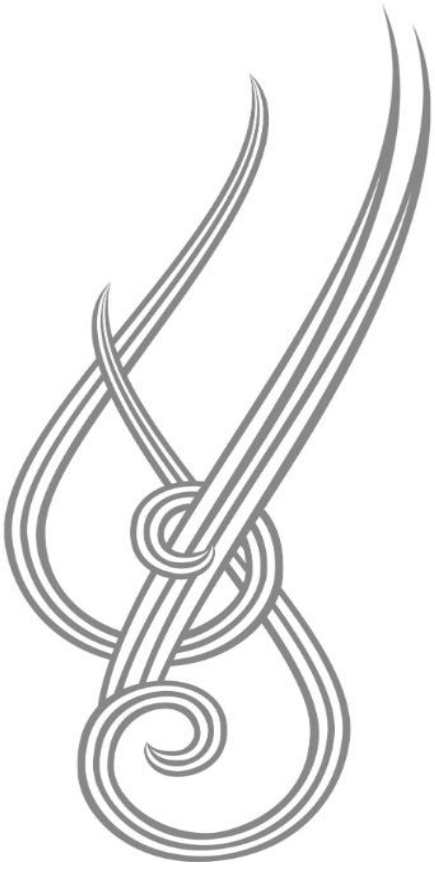
MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

MSD Historic Claims

Business Process and Guidance

(updated January 2026)



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Introduction

The MSD Historic Claims Business Process and Guidance (the Handbook) replaces the version titled MSD Historic Claims Business Process and Guidance Version 3.2, July 2025.

This update reflects the introduction of the '*Common Payment Framework*' (Appendix 1) and amendments made to the rapid payment framework in December 2025, and the development of any process and practice changes since the previous version of the Handbook.

The MSD Historic Claims team are committed to continually reviewing how we assess and respond to claims to ensure we deliver a service that is consistent and fair, and is mana manaaki; a positive experience every time. As part of this commitment the processes, policies and guidance will be subject to review and amendment over time.

The following process provides guidance for responding to claims. Some claims may benefit from a more individualised approach, including in response to unanticipated issues.

Historic Claims Application (the Application)

Design work began in April 2019 for the development of an application database for Historic Claims to replace the manual system of recording and processing claims.

The Application is also a reporting tool and therefore relies on the input of accurate recording of claim details. It does not contain all information about the claim or claimant as this information is saved in the claimant file in Objective[1]. However, there are links to relevant documents in the claimant file in Objective copied into the claimant's record in the Application.

User Guides have been developed that provide step by step instructions for all points of the claims process where information is required to be entered into the Application.

Terminology

State care

For the purposes of this Handbook State care refers to a child or young person who has been placed under the supervision, custody, guardianship or has come to the notice of Child, Youth and Family or its predecessors.

Claimant

For the purposes of this Handbook, a claimant is a person who has been confirmed as eligible to make a claim as part of the Ministry's Historic Claims process.

1. Intake

Claims may be made to the Ministry of Social Development (MSD) by a person directly or via their nominated agent or representative or via a legal representative. Once it has been

[1] Objective is the Ministry's main document management system.

confirmed that the person meets MSD's eligibility criteria, every claim received is recorded in the Historic Claims Application (the Application).

1.1 Direct claims

Direct claims are usually received by phone, email or mail. Claims may also be made, with the consent of the person, by a representative or agent. Claimant Support Specialists receive the claim and work with the person to establish if they meet MSD's eligibility criteria to make a claim.

Where a person is seeking to act on behalf of a claimant, confirmation giving them authority to act must also be provided to Historic Claims in writing.

Prior to any information being gathered (beyond any initial written contact), a Claimant Support Specialist will provide information to the person about how MSD uses their personal information including who MSD may share their information with and why. As part of these conversations the Claimant Support Specialist will also:

- ensure that Historic Claims has sufficient information to confirm whether or not a person is eligible to make a claim;
- provide information about the claims process, what to expect, and answer any questions the claimant may have;
- where possible, help claimants to access counselling support or other services.

1.2 Legally represented claims

A person may choose to progress their claim via a legal representative rather than directly with MSD. In these circumstances MSD is usually advised in writing of claims made via a legal representative. This may be by way of a completed Claim Registration Form, Statement of Claim, letter outlining a person's concerns and/or Letter of Offer[2]. These will be processed and recorded in the Application after eligibility has been confirmed. The date the claim is registered is the date that the first of any of the above documents is received.

Legally represented claimants may access the same support as direct claimants during the claims process.

1.3 Confirming eligibility

Eligibility needs to be confirmed for all claims. This may require additional steps (such as requesting files) to determine eligibility. Checks may also need to be carried out to determine whether the concerns raised have been previously considered by Oranga Tamariki.

Claimant Support Specialists are responsible for determining whether a claim meets the eligibility criteria. This decision is recorded in the Application. A person is advised of the decision by:

[2] A letter outlining a person's concerns which also contains a settlement offer for which the person would be willing to settle the claim for.

- a letter of acknowledgement confirming registration of their claim and providing information about the claims process and a copy of the Historic Claims Fact Sheet which includes information about how a claimant's information is treated;
- or a closure letter advising that they are not eligible to make a claim with MSD.

A person is eligible to make a claim to MSD if they:

- had been in the care, custody, guardianship, or came to the notice of the Child Welfare Division, the Department of Social Welfare, or Child, Youth and Family **before** 1 April 2017, **and**
- believe they were harmed as a result of abuse or neglect while in care[3].

A person is **not eligible** to make a claim to MSD if they do not meet the above criteria.

In cases where a person is not eligible to make a claim to MSD it may be appropriate to provide contact details to the person making a claim of other organisations or services that may be able to assist (e.g. Ministry of Education, Ministry of Health, Faith-based organisations or Accident Compensation Corporation) or to assist them to connect with an agency by agreeing to pass on their contact information. Note: where personal information is being shared with an agency (such as contact information), it is important that a claimant's verbal consent is obtained and is clearly documented in Objective.

In some cases, a person will be eligible to make a claim to MSD but some allegations will be out of scope of MSD's claims process. Allegations that are not in scope of MSD's claims process include allegations relating to events that took place:

- at an educational placement including Residential Special Schools, schools attached to social welfare residences or other schools. For further information see '*Historic Claims Policy on Ministry of Education Claims*';
- at a health institution such as a psychiatric hospital;
- at a non-government organisation (NGO) placement where the claimant was not in the care of or custody of the State at the time; and
- on or after 1 April 2017.

Claims cannot be lodged on behalf of people who are deceased (see '*Policy and Practice Guidance on Deceased Claimants'*).

1.4 Second claims or revisited claims

MSD provides a claims process where the general expectation is that each claimant brings only one claim against MSD relating to their time in care and any resolution currently agreed upon is in full and final settlement.

[3] 'Care' is defined for the purposes of eligibility as a person who has been in the care, custody, guardianship, or has come to the notice of the Child Welfare Division, the Department of Social Welfare, or Child, Youth and Family.

However, there may be the occasional situation where it is appropriate to consider a request for a second claim to be registered or for MSD to revisit a claim where a payment has already been made.

For a second claim to be registered or for a claim to be revisited, the General Manager, Historic Claims must approve the request. For further information see *Requests to register second claims or revisit claims.*

1.5 Prioritisation of claims

Claims are allocated for assessment in the chronological order in which they are received in order to ensure fairness and equity across all claimants. However, claims can be prioritised in the following situations:

- where a request is made by a claimant or their representative or agent to have a claim prioritised it will be considered by the General Manager on a case-by-case basis at any stage in the claims process. Claims that may be considered by the General Manager for prioritisation include:
    - claimants who are at high risk of dying before their claim is assessed if prioritisation was not to occur. Supporting information from a claimant's medical practitioner may be required.
    - claimants who are at high risk of suicide before their claim is assessed if prioritisation was not to occur. Evidence from a claimant's clinician confirming this risk is required.
- where a claimant is 70 years or older, their claim will be automatically prioritised.[4]

Where there are multiple claims that have been prioritised, claims that have been prioritised due to health concerns are to be allocated first, before any claim that is prioritised for age.

2. Provision of personal information

A claimant or their representative or agent may request access to their personal information at any point during the claims process. Requests for personal information are allocated to an Information Coordinator in order of receipt, or by exception as outlined in section 1.5 Prioritisation of claims.

2.1 Acknowledgment of request and preparation for processing

The staff member completing the check:

- confirms that relevant paper records and relevant CYRAS[5] records have been saved into Objective;

[4] This does not apply to any claimant who has passed away prior to allocation of the claim for assessment

[5] CYRAS is Oranga Tamariki's case management system.

- sends an acknowledgement to the requestor (either the claimant or their representative or agent) confirming receipt of the request and advising that the request will be granted (if there are relevant files);
- where an initial search finds no related records, the staff member completing the check will contact the requestor for further information that may assist in searching and identifying relevant records.

If no records can be found the requestor will be advised, and the information request will be closed. The Manager Historic Claims will be informed and will be responsible for determining the next steps to be taken for the claim taking into account the guidance in section 7.9 Loss of claimants records (where applicable).

2.2 Personal information request allocated for redaction

Once the records are received and scanned, an Information Coordinator creates working copies of files and redacts information in accordance with the Privacy Act and any other relevant legislation.

The claimant or their representative or agent is contacted to confirm how they want to receive a release of their information. Release/pick-up letters are prepared, and the file is sent via ShareFile[6] or signature courier to a secure place of business.

3. Sharing of information with other agencies relating to safety concerns

3.1 Sharing of information

Where a claimant raises concerns about the care or treatment provided to them that relates to a current Oranga Tamariki, NGO, or other government agency staff member or caregiver who works with children, this information may need to be shared with that agency if the concerns raise current safety concerns for children. This helps to keep children safe now and in the future.

See the Historic Claims Privacy Fact Sheet – '*Your Information is Important'* for more information.

3.2 Safety Checking

A safety check is completed to identify any current safety risks to children, by identifying any staff members or caregivers referred to in a claim who may be currently employed by Oranga Tamariki, MSD, or an operating NGO.

The need for a safety check may be identified by:

[6] "Sharefile" is a secure file sharing system that allows information sharing with external agencies and individuals electronically.

- when a new claim is registered or a letter of offer is received from a claimant's lawyer;
- at interview or during discussions with the claimant; or
- during an assessment, if previously unknown information is found on the claimant's file, or at any other point that details of alleged perpetrators are established.

Information that requires safety checking is referred to the Lead Claims Advisor (or nominee) to carry out the safety check. Staff who are conducting safety checks may need to make contact with Oranga Tamariki or operating NGOs to check whether staff members are employed by that agency.

The outcome of these safety checks may result in referrals to Oranga Tamariki, NGO's, other Government agencies or the Police. Safety checks will be referred to the Lead Claims Advisor for consideration and for any relevant referrals to be made, in consultation with MSD Legal where appropriate (e.g. filed claims).

3.3 Court orders prohibiting disclosures of information

Court orders prohibit some disclosures of information contained in claims that are filed with the Court. Breach of these orders would likely constitute contempt of Court.

If the intention is to make a safety referral in relation to an allegation raised in a claim filed in Court, the Lead Claims Advisor, relevant Senior Claims Advisor or their manager will consult with MSD Legal prior to the referral being made. MSD Legal are available to provide legal advice as needed when making decisions in other cases.

3.4 Referring care and protection concerns

During the claims process, other information may be gathered that raises concerns about the care and protection for a child or young person outside of the safety check process. Where a staff member has concerns about the safety of a child identified outside of the Historic Claims safety checking process, these concerns should be reported to Oranga Tamariki as a report of concern in accordance with the Ministry's Child Protection Protocol. The referral should be discussed with their Team Leader or Manager prior to any referral being made.

4. Assessment of a Claim

There are two types of assessment a claimant can choose from: a rapid payment or an individualised claim assessment. Claimants who choose a rapid payment are also free to reject any rapid payment offer that is made and request to have an individualised claim assessment.

MSD introduced rapid payments into its claims process in November 2022 to offer options to claimants about how their claim is resolved depending on what is important to them.

Rapid payment offers are able to be progressed within a faster timeframe than is available under an individualised claim assessment.

4.1 Rapid payments

Rapid payments are not calculated based on a person's individual experience and concerns, but rather the length of time a person was involved with Child Youth and Family or its predecessor agencies. This acknowledges that the longer a person has been involved with the State, the more likely they will have experienced repeated harm.

These payments can be calculated more quickly as a person's care records will not be checked to consider what information supports a person's specific concerns. Further information about rapid payments can be found in section 6.

Any claimant that chooses to receive a rapid payment is still entitled to all other parts of the claims process. This includes having the opportunity to tell their story, receive their care files, be supported to access counselling and receive an apology for their experience.

4.2 Individualised claim assessments

An individualised claim assessment considers a claimant's specific concerns and care experience including reviewing a claimant's state care records. Allegations that are able to be taken into account for recommending a settlement offer are classified and payment is determined by using the *'Common Payment Framework'* (Appendix 1). Further information about individualised claim assessments can be found in section 7.

5. Gathering information to support the assessment

5.1 Discussing assessment options with a claimant

Prior to beginning an assessment, a discussion should be had with a claimant about their assessment options and what each option might mean for the outcome of their claim. It will be important for the staff member to discuss the main differences between the assessment options, the information the claimant would need to provide for each option, timeframes and how outcomes might differ (if known).

5.2 Gathering information from a claimant

For claimants who choose a rapid payment, detailed information does not need to be gathered from a claimant about their concerns or their care experience unless they wish to provide this. For some claimants, it will be important for them to have the opportunity to tell their story and therefore they may still wish to discuss their care experience before an assessment begins.

In order to assess a person's claim under an individualised claim assessment, information needs to be gathered from the claimant about their experience and what they are seeking from MSD. Claimants can provide this information in a variety of ways, depending on their preference and circumstances. This may include one or more of the following:

- a face-to-face meeting. Where a face-to-face meeting is held, all efforts will be taken to ensure that the claimant is comfortable with the venue (although meetings will not be held in their own home);
- audio visual link (AVL);
- telephone conversations;
- in writing;
- gathering information from other sources (with the claimant's consent) such as a counsellor or Police; or
- a Letter of Offer and/or Statement of Claim from a legal representative.

Information may be provided by the claimant via a combination of channels. The claimant will be given the time they need to share their allegations, and at a pace they are comfortable with.

In addition to collecting allegations/concerns from a claimant, some claimants may wish to provide written supporting information that can be considered as part of the assessment. For example, this could include information to confirm the claimant has lodged a complaint with the Police or a sensitive claim with ACC relating to abuse experienced in care.

Staff may need to clarify with the claimant particular details to enable allegations to be correctly classified (such as frequency and severity) or assessed under a Step 2 (such as identification details of an alleged perpetrator). This clarification can occur at any stage during the process.

6. Rapid Payment assessment

6.1 Introduction

For a person to be eligible for a rapid payment, they must meet the general claim eligibility criteria (see section 1.3) including having a concern that they were harmed as a result of abuse or neglect while in state care.

Rapid Payments are primarily calculated by considering how long a person has been involved with Child, Youth and Family and its predecessor agencies (CYF). The payment bands are:

Under 3 Years	$15,000
3 – 14 years	$30,000
Over 14 years	$40,000

Where applicable, a further payment of $5,000 may be added to acknowledge placement at an NGO-run bush programme. The relevant NGO-run bush programmes are[7]:

- Whakapakari
- Moerangi Treks
- Eastland Rescue Youth Trust
- Tarawera Treks/Tarawera Trust
- Wairaka Kokiri
- Whaakaro Kotahi Charitable Trust/ Te Tewha Tewha Trust

The Rapid Payment Calculator is used by staff to record and calculate the payment to be offered.

6.2 Calculating the payment

To calculate the payment, staff first establish the length of time the claimant was involved with CYF and then identify if an NGO-run bush programme payment applies.

Period of involvement

The period of involvement extends from the first date a claimant came to the notice of CYF as a client through to the last date they ended involvement with CYF as a client.

The length of involvement is established by staff looking through a claimant's state care records (CYRAS file and/or scans of a claimant's personal or family file). When carrying out this calculation, staff will need to consider the following:

- involvement is defined as someone who is in the care, custody or has come to the notice of CYF or its predecessor agencies for care and protection or welfare concerns. This includes coming to notice for offending;
- care and protection or welfare concerns do not include things such as:
    - concerns that do not relate to the claimant such as concerns that are confined to a sibling;
    - requests for financial support to assist parents or caregivers where the request or concern does not include any specific care or welfare concerns about the claimant;
    - the seeking of maintenance or child support payments for the custodial parent and in the absence of any specific care or welfare concerns about the claimant;
    - adoption of the claimant where the only involvement of CYF is carrying out its statutory functions under the Adoption Act 1955 and in the absence of

[7] This list contains bush programmes in isolated settings run by NGO providers who were contracted by Child, Youth and Family or its predecessor agencies to provide care for young people in state care. This list is not a conclusive list of bush programmes, but rather programmes where there is sufficient evidence that more serious abuse may have occurred. This list may be updated from time-to-time if more information comes to hand.

any specific care or welfare concerns about the child or young person being adopted.

- where a person has multiple entries and exits into care, the entire period from beginning to end is to be used for the calculation except where there is/are educational or psychiatric placement(s) that are more than half of the time the person was involved with CYF or is post 1 April 2017 (see section 6.3 for more information)

The end date is defined as the date at which the claimant had no further involvement with CYF as a client. Where the claimant does come to the attention of CYF, but there are no orders in place for the claimant and they are of an age where they fall outside the jurisdiction of the Act[8], then that does not constitute involvement for the purpose of calculating a rapid payment. Examples of this include but are not limited to:

- the claimant's child has come to attention, or
- where welfare concerns are raised about other children in the home and the claimant is of an age where they fall outside the jurisdiction of the Act[8].

NGO-run bush programme payments

An additional payment of $5,000 may be added to acknowledge particular placements where it is known more serious abuse occurred. All documents containing information about the claimant's concerns or allegations should be reviewed to determine whether this additional payment should be included as part of the final rapid payment offer. This includes reviewing:

- claim registration forms;
- notes from an interview and/or conversations the claimant has had with historic claims staff;
- information from other sources about the claimants' care experience;
- a letter of offer from the claimant's solicitor;
- a Statement of Claim where the claimant has filed proceedings in court.

The purpose of that review is to identify whether a person has raised concerns about conduct while placed at an NGO-run bush programme listed in section 6.1. This additional payment is included based on the information provided to Historic Claims by the claimant. Verification of attendance at bush programmes from the claimant's records is not necessary.

Once all relevant information has been entered into the Rapid Payment Calculator, a total payment is generated by the calculator. Rapid payments cannot exceed $45,000.

[8] The Child Welfare Act 1925; the Children and Young Persons Act 1974 or the Oranga Tamariki Act 1989 as appropriate.

6.3 Exclusions from rapid payment calculations

As noted in section 1.3, allegations that relate to events that took place at an educational placement including a Residential Special Schools or a health institution such as a psychiatric hospital do not fall within the scope of MSD's claims process. There are other redress processes run by other agencies for these types of allegations.

However, for the purposes of calculating a rapid payment only, educational or health placements can be included when calculating the 'length of involvement' except where they fall under the exclusion below. Please note that any inclusion in the "length of involvement" calculation cannot be viewed as MSD responding to those allegations and claimants continue to be free to lodge a separate claim with the relevant claim agency.

When calculating the 'length of involvement' period, the following periods of time shall be excluded:

- Unless agreed otherwise by MSD and Oranga Tamariki, any period post 1 April 2017;
- Where from a brief review of the claimant's files it is clear that the claimant spent more than half of the time they were involved with CYF or its predecessor agencies in educational or health placements, the length of any such placement(s).

6.4 Where a claimant has shared concerns about their time in care

If a claimant has shared concerns about their time in care:

- all allegations made by a claimant are to be recorded in the Data Collection Template and also inputted into the Application;
- staff should identify any allegations requiring a safety check if this has not been completed or an updated safety check if new information has been received, and progress these for checking (see section 3.2);
- staff should identify any allegations relating to either a current or past staff member or caregiver of an operating care NGO and share these with that NGO to inform them of the allegations. Though care needs to be taken with claims that are filed in Court (see section 7.8).

6.5 Review of rapid payment assessment

A claimant may request a review of their rapid payment assessment and settlement offer only where:

- they believe the start and/or end dates of involvement were incorrectly identified, and/or
- they believe an error was made in calculating the rapid payment amount.

7. Individualised Claim Assessment

It is important to note that Historic Claims do not investigate allegations of abuse. It is also acknowledged that the team cannot measure the significant impact abuse has had on a person's life. Allegations are assessed based on the incident or event itself for the purposes of settlement, and not the impact of that abuse.

7.1 Steps prior to allocation

Prior to allocation of a claim for an individualised claim assessment, the claimant's Objective file is reviewed to ensure that all relevant information is available, which may include an audio recording of a meeting with a claimant and notes, or a Letter of Offer, as well as confirming that the claimant's personal and family files are available.

7.2 Preparing for assessment

Once a claim is allocated, the staff member reviews the information provided by the claimant to identify the allegations to be assessed. This may include reading the Letter of Offer or Statement of Claim, listening to interview recordings and reviewing relevant files and notes held on the claimant's file. Each allegation is then recorded in the Application.

For further information, see '*Practice guidance – How to identify and write an allegation'*.

Once each allegation has been entered into the Application the complete list can be generated and downloaded. This list may be helpful when carrying out the assessment or can be used with claimants to confirm that all the allegations they would like Historic Claims to look at as part of their claim have been identified and correctly understood (if this would be helpful for the claimant).

Prior to beginning an assessment, the staff member reviews all the allegations to be assessed to identify any:

- allegations that may require additional checks, including allegations that may require a Step 2 (see section 7.5) analysis, so that additional files can be ordered as early as possible;
- any allegations that are the responsibility of other Crown redress agencies to assess;
- further allegations that relate to an operating NGO so that appropriate consultation can be had; and
- any allegations requiring a safety check if this has not been completed.

The following resources should also be gathered to guide the assessment:

- Historic Claims practice guidance and any other policies that guide how an assessment is to be carried out;
- a summary of policies, legislation, legal authorities, manuals and practice guidance that relate to the time period being assessed and links to full documents;

- the '*Common Payment Framework'* (Appendix 1) and the '*Common Payment Framework Operational Guidance'* (Appendix 2).

7.3 Assessing a Claim

An assessment of each allegation included in the claim is based on the information held in the personal and family files (including CYRAS records where available) relating to the claimant's involvement with CYF or its predecessors.

Key dates and decisions relating to the claimant's time in care are noted. This information helps the staff member understand the role the State played in the claimant's life at different points, enables the construction of a timeline and assists in providing feedback to the claimant about their time in care. Further information about timelines can be found in '*Practice Guidance – Timelines*'.

For each allegation the staff member will capture information that will help them to:

- complete a fact check to confirm that MSD or its predecessors had a responsibility for the claimant at the time of the alleged event;
- identify any relevant policy, legislation or guidance;
- identify any information found in the file that points against the alleged abuse or conversely points towards the alleged abuse having occurred; and
- classify the allegation using the 'Definitions of abuse and neglect' section of the '*Common Payment Framework'* (Appendix 1).

All relevant information is recorded in the Claim Assessment Template and in the Application as appropriate.

An assessment of the claim will also consider any other significant abuse identified by the staff member during the review of the claimant's records.

Advice can be sought from the Senior or Lead Claims Advisor on technical matters, wherever appropriate, to ensure the correct legal statuses, policies and legislation, are cited in the Claim Assessment template for each allegation where appropriate.

Once the available information has been gathered it will enable and require an objective decision to be made as to whether the allegation can be taken into account for the purpose of recommending a settlement offer. Advice and guidance should be sought as appropriate from the staff member's Team Leader in the first instance. The Senior Claims Advisor, Lead Claims Advisor, Strategy Team and/or MSD Legal are also available to assist if needed. The rationale for any recommendation must be clearly documented in the Claim Assessment Template.

Any allegations taken into account for the purposes of recommending a settlement offer are classified using the 'Definitions of abuse and neglect' section of the '*Common Payment Framework'* (Appendix 1).

For further information see '*Legal framework underpinning Claims Resolution process*'[9] and *'Common Payment Framework Operational Guidance'* (Appendix 2).

7.4 Allegations not taken into account

An allegation will be taken into account for the purposes of recommending a settlement offer unless any of the following apply:

- they meet the criteria outlined in section 7.5 'Step 2' and should therefore be considered using the guidance in that section;
- it has not been confirmed that MSD or its predecessors had a responsibility for the claimant at the time of the alleged event;
- we are aware the allegation has been previously reviewed and considered by MSD or another agency (either government or non-government) and there are insufficient factors to indicate it may be appropriate for the claim to be reviewed. For allegations previously reviewed by MSD, see further the document titled '*Requests to register second claims or revisit claims'.*
- Information has been identified in the assessment that points against the allegation.

  Examples of the type of information that may point against the allegation include:
  - where an allegation of physical abuse has been made but there is clear medical information which does not support physical abuse;
  - documented investigation of an allegation which has been raised in the claim, where that investigation is deemed to meet the reasonable standards of the time and which concludes that the alleged incident did not happen;
  - records that indicate regular social worker visits and face to face contact with the claimant where the opposite is alleged;
  - clear information that a named staff member or caregiver about whom an allegation is made was not present at the time of the alleged abuse.

Where there is some ambiguity about the effect some information may have on the claim, advice and guidance should be sought as appropriate from the staff member's Team Leader.

It is not necessary to identify information which supports an allegation in order for that allegation to be taken into account for the purposes of recommending a settlement offer.

[9] This document is legally privileged.

However, where such information is identified this should be recorded and referenced. This provides valuable information that assists with providing feedback to the claimant.

Given the difficulties of memory and the length of time that some claimants wait before bringing a claim, if the claimant has misidentified the person they make allegations against, this does not automatically point against taking the allegations into account for the purpose of settlement.

7.5 Step 2 – Additional information for particular allegations

Where the allegations are of a more serious nature, consideration of additional information provides increased rigour around the assessment of these allegations. This enables MSD to have a better understanding of the more serious abuse alleged by those who were in care and provides confidence in the robustness of the information shared with current care providers including Oranga Tamariki.

It also ensures payment recommendations are fair, consistent and align with past payments under the '*Common Payment Framework*' (Appendix 1).

Step 2 analysis is required where allegations against a carer involve any of the following:

- More severe and chronic physical abuse or neglect by a carer;
- Significantly severe physical abuse or neglect by a carer;
- More severe and significantly severe sexual abuse by a carer;
- Any allegation that falls into Category Three or higher of the 'Payment categories' set out in the '*Common Payment Framework*' (Appendix 1);
- Any allegation for which a payment is being considered under the '*Guidelines on Discretionary Payments for Abuse in State care claims*'.

Step 2 analyses require consideration of whether, on the basis of the information gathered, it is reasonable for the allegation to be taken into account for the purpose of making a settlement offer.

The types of additional information that may be considered as part of this analysis includes:

- other claims made against the alleged abuser;
- other claims involving allegations about specific providers, programmes or institutions;
- institutional files about residences or providers;
- information held in the alleged perpetrator's staff or caregiver files;
- inviting the claimant, or their representative, to provide their own information that may support the allegation. For example, information that they have lodged a criminal complaint with the Police or made a sensitive claim with ACC. They may also be invited to provide additional detail about the nature of the alleged

abuse/neglect, details of and description of the alleged perpetrator and the frequency of the abuse/neglect.

Further information about information sources can be found in '*Practice guidance – Information sources for assessment'*.

The following considerations may assist when undertaking a Step 2 analysis of an allegation of abuse:

- whether documents confirm contact between the person the claimant alleged abused them;
- whether the claimant's allegations are consistent with information MSD holds about the alleged staff member, caregiver or institution. This may include consideration of other allegations received or documentary information held by MSD;
- whether descriptions and/or modus operandi described align with other known allegations; or
- the certainty of other similar allegations for example criminal convictions or complaints made and investigated at the time.

Further guidance about Step 2s can be found in '*Practice Guidance – How to prepare a step 2 analysis*'.

7.6 Seeking Legal Advice

From time to time, there will be claims that require legal advice. For example, where it is not clear whether an alleged perpetrator would fall under the 'carer' definition.

All requests for legal advice must be emailed the Legal inbox and included in the Application.

7.7 Allegation against a current MSD staff member

Allegations against current MSD staff may require a more detailed assessment. In addition to any obligations to the claimant, if an allegation is made about a current staff member, MSD has an obligation to the employee to advise them of the complaint and to manage this in a fair and transparent way. In these circumstances the Manager Historic Claims will seek guidance about the approach to assessing the claim.

Note: if the staff member finds new information that indicates the allegations in the claim relate to a current Oranga Tamariki or NGO staff member they should check that a safety check has been completed and refer these for checking if this has not been completed (see section 3.2).

7.8 Engaging with operating Non-Government Organisations (NGO)

Where an allegation is made in relation to either a current or past staff member or caregiver of an operating NGO, information may be shared or gathered to support the assessment of the claim. There are Court Orders in place that prohibit some disclosures of information in claims that are filed with the Court. Breach of these orders would likely constitute contempt of Court. MSD Legal should be contacted before sharing any details of a claim filed in Court with an NGO.

Where an allegation is made in relation to either a current or past staff member or caregiver of an operating NGO the staff member will:

- prepare a summary outlining the NGO's known involvement with the claimant and the relevant allegations relating to that NGO;
- identify specific information needed to support the assessment of the claim;
- discuss with the Lead Claims Advisor, and get advice from MSD Legal if necessary, on the best approach to consult with the NGOs;
- advise the claimant (or their legal representative) that the Ministry is intending on consulting with the NGO. Any concerns raised by the claimant about this engagement should be considered and addressed so far as possible.
- at the conclusion of their assessment the staff member will refer a copy of the draft outcomes for the relevant allegation/s to the NGO for their review and feedback.
- if the NGO provides information that is used in the claims assessment, this is to be set out in the settlement offer letter.

7.9 Loss of claimant records

A claimant's records should confirm their placement in the home, residence or provider at the time the allegation occurred in order for their allegation to be taken into account for the purpose of recommending a settlement offer.

CYF and its predecessors were obligated to maintain and retain records for children and young people who were placed in their care, custody or guardianship. In some instances and for various reasons some of those records have either been lost or destroyed making it impossible to verify facts such as legal status and placement details. The absence of those records places the claimant at a disadvantage for which they should not be penalised.

Where records are absent, further investigation will be required to enable an assessment to be made about whether the allegation can be taken into account for the purpose of recommending a settlement offer. Additional steps should be taken in an attempt to confirm the key facts of the claim such as reviewing any potentially relevant residential registers, logbooks and diaries, and caregiver records to determine if the claimant was placed as stated. Where no information can be identified, the staff member will need to

determine whether the lack of information means the allegations are not taken into account for the purpose of recommending a settlement offer. Advice should be sought from their Team Leader in the first instance.

7.10 Referencing guidance

Where information has been relied on for the purpose of determining whether an allegation should be taken into account for the purpose of recommending a settlement offer, referencing allows for the information to be easily located where necessary. Referencing becomes crucial if the claimant seeks a Review.

There are two types of referencing – (1) reference the allegation and (2) referencing information used to assess the claim. These references are recorded in the claim assessment template and the relevant fields in the Application.

Referencing allegations
Staff record a time stamp, or a page and paragraph number, indicating where the allegation was mentioned in the claimant's description of their time in care.

Multiple references can be recorded, where the same allegation is mentioned more than once in their description of their time in care.

Referencing information used to assess a claim
A reference should include the name of the document and/or the file reference and specific page/folio that the information is on where available.

Specific reference examples include:

- 50000XXXXX, page 1
- 50000XXXXX, folio 2
- R 12 XXX XXX, page 3
- R 12 XXX XXX, folio 4
- Child Welfare Manual 1984, Section A.1.23
- 'Name of claimant' CYRAS, page 1
- Delium DCN.001.0014
- Objective 'Title of file/document', page 1

7.11 Developing recommendations for payment

The allegations taken into account for recommending a settlement offer are recorded in the Summary of Allegations section of the Claim Assessment template. The staff member uses these allegations to determine the appropriate payment category and step from the '*Common Payment Framework*' (Appendix 1). Guidance can be found in the '*Common Payment Framework Operational Guidance'* (Appendix 2).

8. Settlement documentation and sign out

8.1 Preparation of settlement documentation

At the same time as the assessment is being completed, the staff member will also prepare the following documentation:

- Settlement Offer Letter;
- Settlement Agreement; and
- Apology Letter and accompanying Memo to the Chief Executive.

Further guidance on these documents can be found in the guidance titled '*Settlement Documentation*'.

If the claimant has died prior to their claim being resolved, the documents will require some edits. See '*Policy and practice guidance on deceased claimants'* for information.

8.2 Sign out of Claim Assessments

Team Leaders are responsible for monitoring claims through the assessment process, ensuring outcomes align with policies and guidelines.

Once completed, settlement recommendations (including recommendations for no payment) under an individualised claim assessment are referred to the Consistency Panel for endorsement. The Consistency Panel's role is to ensure that all recommended payments fall within the correct category and step of the 'Payment categories' set out in the '*Common Payment Framework'* (Appendix 1), and that all recommended payments are consistent, fair and in line with past and present payments under the '*Common Payment Framework'*. The make-up of the panel may change from time to time, but will generally include senior staff of Historic Claims not directly involved in writing of assessments (for example, the Director Strategy, Lead Claims Advisor or Lead Strategic Advisor) as well as a member of the MSD Legal team.

Once endorsed, the staff member responsible for the assessment will complete the DCE memo for the claim and send this through to their Team Leader for review and approval. The completed DCE memo will be endorsed by the General Manager Historic Claims, sent to the Chief Legal Advisor, for certification before being sent to the Deputy Chief Executive, People and Capability, who has the delegation to approve settlement payments.

Once the memo is approved the staff member responsible for the assessment will record any relevant information on the individual claimant's file and the Application. This includes confirmation of the approved settlement offer for the claimant.

9. Feedback with claimants

9.1 Guidance for providing feedback to claimants

The staff member responsible for providing the outcome of the assessment to the claimant contacts the claimant to arrange feedback. Feedback is an important part of the claims process, especially for individualised claim assessments. It allows for MSD to acknowledge a claimant's account of their experience in care and provide factual information about their involvement with CYF or its predecessors, support their understanding about their care journey and where appropriate, provide a settlement offer.

It is important for claimants to have a clear understanding of the claims process from the point of first contact and that needs to be reinforced throughout their contact with Historic Claims, including that:

- it is an Alternative Dispute Resolution (ADR) process;
- it has limitations to the way claims are assessed. It does not seek to establish the facts of a claim in the same way a court does;
- we do not usually interview anyone other than the claimant;
- we do not accept allegations but will take certain allegations into account for the purposes of making a settlement offer.

It is helpful to begin the feedback conversation by reinforcing the purpose and limitations of the process. Caution and careful consideration should be applied to language which infers taking responsibility for an allegation of abuse, given that this is an Alternative Dispute Resolution process and does not test evidence to the degree that a Court would. Further guidance to support these discussions can be found in the document titled '*Engaging with claimants under the new Historic Claims process (key messages)*'.

We offer feedback meetings to both direct and represented claimants.

For those claimants who have chosen a rapid payment (and therefore have not had their care files reviewed in detail), the feedback will likely be more limited to any particular questions the claimant may have about their care experience, a time-line (if requested by the claimant) and providing the settlement offer.

9.2 Offer acceptance and administrative process

For direct claimants

The Settlement Letter and Settlement Agreement will usually be provided by email to the claimant directly after the feedback meeting or it may be provided in hardcopy at the meeting if it is in person. The settlement documents can also be sent by mail if necessary. If providing the documents in person to the claimant, the staff member should strongly encourage claimants to take away the document to read it and consider before signing as well as seeking legal advice if they wish. It will not generally be appropriate to allow a claimant to sign the agreement at the feedback meeting.

Where the claimant accepts the Settlement Offer and returns the signed Settlement Agreement to MSD; the staff member providing feedback to the claimant will:

- obtain verified bank details for the account where the claimant would like any financial payment to be made;
- obtain written consent of the claimant and the bank account holder if the bank account is not in the name of the claimant (see "Alternate Bank Account Consent form");
- confirm the physical address or email address the claimant would like their written apology and/or closure letter sent to; and
- once the signed Settlement Agreement and verified bank details have been received, the staff member will, where required, arrange financial payment to the agreed verified bank account and arrange the sign-out of an apology letter by the Chief Executive as well as a closure letter to send to the claimant.

For represented claimants:

- the Settlement Letter and Settlement Agreement will be sent to the claimant's legal representative in accordance with any administrative process in place at the time;
- if the claimant accepts the offer, their lawyer will confirm acceptance;
- where required, verified bank account details will be obtained;
- once acceptance has been confirmed, financial payment to the agreed verified bank account will be arranged in line with any payment policies at the time. In conjunction, the staff member will (where relevant) arrange the sign-out of an apology letter by the Chief Executive and send an original copy along with the signed Settlement Agreement to their lawyer, plus a copy to Crown Law for filed claims;
- For filed claims, the claim cannot be closed until a Notice of Discontinuance is received from the claimant's lawyer (which will likely be passed on from Crown Law).

Once payment has been made, the staff member is to update the Application with all relevant redress information. The claim in the HCA can be closed once all outstanding matters above have been addressed.

10. Rejection of assessment outcome and offer

10.1 Review options

Claimants can request a claim review if they are dissatisfied with the outcome of their claim under an individualised claim assessment. Where the Settlement Offer is rejected by the claimant, next steps will be based on the claimant's reasons for rejecting the offer and their individual circumstances. A review **may** include a:

- review of an allegation to ensure the accuracy of the outcome based on the existing information; and/or
- completing a detailed assessment of an allegation by considering all available information; and/or
- payment review, to confirm that the claim outcome and payment category and step is consistent with the 'Payment categories' set out in the '*Common Payment Framework*' (Appendix 1).

All reviews are carried out by a staff member who was not the initial assessor or peer reviewer.

All reviews will be completed in accordance with the Historic Claims current assessment model outlined in section 7 of this document.

All reviewed claims will require Consistency Panel endorsement, and where changes are made to their settlement offer, DCE approval will be sought.

The claimant will be kept informed about what is happening with their claim and the outcome of the review. Should they remain dissatisfied with the outcome of the review they will be informed of their options, which could include seeking legal advice, making a complaint to the Ombudsman or requesting a rapid payment (if not previously received).

Appendix 1

Common Payment Framework

January 2026

About the Framework

The common payment framework (the Framework) is the tool to guide decision making about what payment is offered to survivors of abuse in care who are accessing redress from government agencies under their alternative disputes resolution processes. It will be applied consistently by agencies when determining a payment offer for abuse in care redress following assessment of a claim.

There are two sections to the framework:

1. Payment categories [pages 2 – 4]. The categories set out what payment will be offered for what kind of abuse and neglect.
2. Definitions of abuse and neglect [pages 5 – 10]. The definitions explain key terms used in the payment categories.

Notes:

- The Framework does not determine what allegations are considered for the purposes of making a payment offer under this Framework. Rather, that is the function of the assessment that is completed in accordance with the redress agency's claims process.
- This Framework is to be used to determine payment for claims that are assessed by a State abuse in care redress agency following an individualised assessment. It is not used for claims that are using a rapid payment process as these have their own separate payment framework.
- This Framework does not provide redress for proven allegations of torture (as defined under the United Nations Convention Against Torture and the Crimes of Torture Act 1989). The consideration of any payment for proven torture sits outside this Framework.

MINISTRY OF SOCIAL DEVELOPMENT TE MANATŪ WHAKAHIATO ORA
ORANGA TAMARIKI Ministry for Children
MINISTRY OF HEALTH MANATŪ HAUORA
Te Tāhuhu o te Mātauranga Ministry of Education
DEPARTMENT OF CORRECTIONS ARA POUTAMA AOTEAROA
Te Puni Kōkiri MINISTRY OF MĀORI DEVELOPMENT
Listening, learning, changing
Mā Whakarongo me Ako ka huri te tai
Crown Response to the Abuse in Care Inquiry

Payment categories

The Payment categories are intended to determine payments for abuse in care redress. However, there may be the occasional claim where a further discretionary payment is appropriate in line with separate discretionary payment policy guidance[10].

The categories and the characteristics described below simplify the complexities of abuse and neglect to provide clear categories and steps that can be consistently applied. There is no intent to minimise a survivor's lived experience or suggest a lesser impact on their lived experience.

The payment amount corresponds to the most serious abuse experienced while also acknowledging the survivor's total care experience. Each payment level recognises that less serious abuse, set out in lower payment levels, may also have been experienced.

There are five categories that range from Less Severe ($7,500 to $20,000) to Extraordinary Severity ($75,000 and over). Each category includes one or more payment steps which move up based on the seriousness of the abuse, whether the abuse or neglect involved a carer or non-carer / other young person, and its frequency.

The Payment categories also enable the recognition of abuse and neglect by non-state carers who are not agents of the State (such as a survivor's parents), and by other young people who were in the same care, residential, education or health setting as the survivor. However, such abuse or neglect must arise from, or relate to, the acts or omissions of the State and have contributed to the abuse or neglect occurring or continuing. Any payment that is made for such abuse or neglect is to recognise the failure of the State.

Category One: **Less Severe** ($7,500 to $20,000)

Step	Characteristics of in care experience	Payment Amount
1	Less severe abuse or neglect by non-state carers or other young people which was infrequent	$7,500
2	Less severe abuse or neglect by carers which was infrequent; or Less severe abuse or neglect by non-state carers or other young people which was frequent	$10,000
3	Less severe abuse or neglect by carers which was frequent	$15,000

[10] All potential category five payments shall be assessed as a discretionary payment and the process described in the discretionary payment policy guidance is to be followed.

4	Less severe abuse or neglect by non-state carers or other young people which was chronic; or More severe abuse or neglect by non-state carers or other young people which was infrequent	$20,000

Category Two: **More Severe** ($25,000 to $35,000)

Step	Characteristics of in care experience	Payment Amount
1	More severe abuse or neglect by carers which was infrequent; or More severe abuse or neglect by non-state carers or other young people which was frequent; or Less severe abuse or neglect by carers which was chronic	$25,000
2	More severe abuse or neglect by carers which was frequent; or Significantly severe abuse or neglect by non-state carers or other young people which was infrequent	$30,000
3	More severe abuse or neglect by non-state carers or other young people which was chronic (more than 2 and up to 4 years)	$35,000

Category Three: **Significant Severity** ($40,000 to $50,000)

Step	Characteristics of in care experience	Payment Amount
1	More severe level abuse or neglect by carers which was chronic (more than 2 and up to 4 years); or Significantly severe abuse or neglect by carers which was infrequent; or More severe abuse or neglect by non-state carers or other young people which was chronic (more than 4 years); or Significantly severe abuse or neglect by non-state carers or other young people which was frequent	$40,000
2	More severe abuse or neglect by carers which was chronic (more than 4 years); or Significantly severe abuse or neglect by carers which was frequent	$45,000

3	Significantly severe abuse or neglect by non-state carers or other young people which was chronic (more than 2 and up to 4 years)	$50,000

Category Four: **Extreme Severity** ($55,000 to $65,000)

Step	Characteristics of in care experience	Payment Amount
1	Significantly severe abuse or neglect by carers which was chronic (more than 2 and up to 4 years); or Significantly severe abuse or neglect by non-state carers or other young people which was chronic (more than 4 and up to 5 years)	$55,000
2	Significantly severe abuse or neglect by carers which was chronic (more than 4 and up to 5 years); or Significantly severe abuse or neglect by non-state carers or other young people which was chronic (more than 5 years)	$60,000
3	Significantly severe abuse or neglect by carers which was chronic (more than 5 years)	$65,000

Category Five: **Extraordinary Severity** ($75,000 and over)

Step	Characteristics of in care experience	Payment Amount
1	This category is reserved for extraordinary claims to recognise where there are clear aggravating factors and/or exceptional circumstances to the level of abuse described in category 4. To be placed in the category, survivors will usually have experienced consistent significantly severe and more severe abuse of 10 years or more. Payment is determined having regard to the individual circumstances of the claim.	$75,000 and over

Definitions of abuse and neglect

This part of the Framework explains the key terms used in the Payment categories that determine payment offers. The intent is to support survivor understanding of the Framework as well as consistent application of Payment categories by government agencies. These key terms are:

- Abuse and neglect, including severity (less severe, more severe, significantly severe): what happened?
- Carers and non-state carers or other young people: who carried it out?
- Frequency (infrequent, frequent, or chronic): how long and how often did it occur?

Frequency of abuse or neglect

How often a survivor experienced abuse or neglect and how long that was experienced for are key factors in their care experience. They are part of determining a payment for abuse in care redress.

The following table will be applied by agencies to consider both how often and how long (duration) the abuse or neglect was experienced to identify the abuse or neglect frequency – infrequent, frequent or chronic – which then links to the Payment categories.

How often?

Once	Infrequent	N/A			
Sometimes (eg "occasionally", "at times")	Infrequent	Infrequent	Infrequent	Infrequent	Frequent
Often (eg "a lot", "every week", "regularly")	Infrequent	Infrequent	Frequent	Frequent	Chronic
All the time (eg "every day", "always")	Infrequent	Frequent	Frequent	Chronic	Chronic
	0 to 6 months	**More than 6 months and up to 1 year**	**More than 1 year and up to 2 years**	**More than 2 years and up to 4 years**	**More than 4 years**

How long? (Duration of abusive period[11])

[11] Which is not necessarily the full period of time in care.

Carers and non-state carers or other young people

For the purposes of applying the Payment categories, **carers** are agents of the State who have care and protection responsibilities for the survivor. They include:

- Caregivers approved and appointed by the agency which has legal responsibility for the survivor;
- Staff of the agency which has legal and/or care responsibilities for the survivor (for example, social workers, teachers, other school staff, hospital staff).

Staff or caregivers of a non-government agency (NGO) or Iwi Social Service contracted to provide care services on behalf of the State agency which has legal responsibility for the survivor will generally also fall into this category, where the relevant State agency would otherwise have that responsibility.

Generally speaking, all other individuals will fall under the definition of non-state carers or other young people.

Further details and guidance on these terms can be found in separate agency guidance.

Abuse and Neglect Definitions and Examples

These guiding definitions separate abuse and neglect into:

- **Types**: physical abuse, sexual abuse, emotional/psychological abuse, and neglect. This supports survivor understanding of what kinds of experiences are recognised and agencies' categorisation of these experiences. The Payment categories don't treat different types of abuse or neglect differently. For example, serious abuse is considered serious whether it's physical or sexual.
- **Severity**: less severe, more severe and significantly severe. This connects to which Payment category is used.
- **Examples**: are given of each type and severity. These aren't complete lists as there's a wide range of experiences across survivors and care settings.

Type: Physical abuse

Definition: Actions that result in, or could result in, physical harm or injury to a survivor.

Severity	A survivor has experienced
Less severe	Actions which ordinarily do not cause bruising or injury. Examples can include: • Excessive corporal punishment that is outside of policy • Misuse of physical restraint that is outside of policy • Slapping/hitting with an open hand, shoving/pushing, hair pulling, ear pulling, tripping, kicking, harsh physical punishment (eg being forced to eat soap) • A staff member/carer directing another survivor to physically assault another survivor[12] • Inappropriate use of medical treatment (eg over medication in psychiatric facilities).
More severe	Actions which ordinarily cause bruising or physical injury such as cuts, welts and blisters. They demonstrate an increased level of violence or force from less severe physical abuse and can involve the use of objects and weapons. Examples can include: • Striking, closed fist punching, whipping, stomping/kicking, blows to the head or body • Being slammed against a wall • Being held forcefully by the neck or throat.
Significantly severe	Physical assaults which result in injuries that would typically require, or should have required, more intensive medical treatment or hospitalisation. Examples can include beatings, punches and assaults which can cause: • A loss of consciousness • Broken bones and dislocated joints • Serious burns • Internal injuries including brain damage. The use of medical treatment where it was administered in circumstances contrary to established medical practice and results in severe pain (eg unmodified electroconvulsive therapy (ECT).

[12] Depending on the nature of the assault, this may be considered more severe.

Type: Sexual abuse

Definition: Actions that involve forcing or enticing a survivor to take part in sexual activities, whether the survivor is aware of what's happening or not. It may or may not involve direct contact.

Severity	**A survivor has experienced**
Less severe	Actions involving exposure, witnessing sexual acts, grooming or sexualised behaviour. Examples can include: • Being exposed to indecent material (whether, written, spoken or visual) • Acts for the purpose of sexual gratification of the perpetrator, eg survivor sitting on their lap, being watched when undressing • Being made to watch or view genitals, inappropriate sexual talk. • Encouraging a survivor to look at pornography or behave in a sexually inappropriate way • Grooming a survivor in preparation for sexual abuse (this may be done via the internet).
More severe	Non-penetrative sexual contact that does not meet the definition of unlawful sexual connection. Examples can include: • Kissing, fondling, rubbing, genital touching or masturbation of or by the perpetrator – may be under or over clothing • Forcing or enticing a survivor to take part in sexual activities whether the survivor is aware of what is happening or not.
Significantly severe	This is contact consistent with unlawful sexual connection as defined by the Crimes Act 1961. Abuse at this level can include: • Sexual connection, rape and oral sex • It can involve a part of the body of the perpetrator or an object • A staff member/carer involving the survivor in the making of pornography or in prostitution.

Type: Emotional/Psychological abuse

Definition: Actions (not physical or sexual) that can demean or harm a survivor emotionally. It is generally verbal but may take other forms. It is generally a pattern of behaviour over time, rather than single or isolated incidents.

Being placed in secure cells, seclusion, timeout, isolation or otherwise detained (such as in a shed or on 'Alcatraz' at the Whakapakari programme) may also constitute emotional /psychological abuse for the purposes of these definitions.

Severity	**A survivor has experienced**
Less severe	Examples at this level can include: • Repeated name calling • Criticising, belittling, demeaning, mocking, misogynist and racist slurs • Accusing, blaming, insulting, threatening abandonment, manipulating, taking advantage, screaming, yelling • Engaging a survivor in criminal acts, making them tell lies • Strip searches that fell outside policy or legislation at the time • Threats of punishment • Harsh or harmful punishment intended to shame • Witnessing or being forced to witness acts of serious abuse • For MSD claims only – continuous placement in secure unit for a period of up to 1 calendar month • Being placed in seclusion in a psychiatric facility without reasonable grounds • Excessive use of timeout where the conditions and/or duration are outside policy or other documented standards.
More severe	Emotional/psychological abuse at this level will generally have persisted over a number of years or is of a nature that is likely to cause significant emotional harm such as threats to kill. Examples can include: • Having a rifle/gun pointed towards the survivor • Being made to dig a hole into which the survivor is threatened to be buried • For MSD claims only - continuous placement in secure unit for a period of more than 1 calendar month.
Significantly severe	Emotional/psychological abuse at this level is likely to be exceptional. It could involve actions which induced the survivor to believe death was imminent such as firing a gun towards the survivor.

Type: Neglect

Definition: Neglect is where the basic needs of a survivor are not being met. This may be physical neglect, medical neglect or supervisory neglect. It is generally a pattern of behaviour over time, rather than single or isolated incidents.

The severity of neglect is determined by considering both the nature of the neglect and the period of time over which it occurred.

Severity	**A survivor has experienced**
Less severe	Examples can include: • An ongoing pattern or practice of allowing or requiring a survivor to miss school unjustifiably • Failing to provide the care required to maintain adequate personal hygiene • Failure to provide sufficient food or clothing or required medical treatment • Condoning the use of drugs, alcohol, or involvement in crime • Living in an environment where for periods of time there is insufficient food, running water, power, functioning toilet • Having to complete chores/work that are inappropriate for the age and stage of the survivor.
More severe	Examples can include: • Endangering the life of the survivor by not taking them to hospital or seeking appropriate medical help for a serious illness or injury where there is confirmation of that illness or injury • Physical neglect to the extent the survivor becomes malnourished or otherwise requires medical intervention.
Significantly severe	Neglect at this level is likely to be exceptional and reflect a situation where there is serious physical and/or medical neglect over a long period of time such that the life of the survivor is threatened.

Information about the Common Payment Framework may also be found at https://www.redress.govt.nz/

Appendix 2

Common Payment Framework Operational Guidance

This guidance is to support redress agency staff to apply the common payment framework when determining payment for abuse in state care claims that are individually assessed.

Date: 27 January 2025

1. Introduction

The common payment framework (the Framework) is the tool to guide decision making about what payment is offered to survivors of abuse in care who are accessing redress from government agencies under their alternative disputes resolution processes. Its purpose is to provide comparable settlement payments for comparable experiences of abuse and neglect in state care.

There are two sections to the framework:

1. **Payment categories** - The categories set out what payment will be offered for what kind of abuse and neglect.

2. **Definitions of abuse and neglect** - The definitions explain key terms used in the payment categories.

It will be applied by agencies to determine a payment offer for abuse in care redress, following the assessment of a claim in accordance with the agency's individualised assessment process.

This guidance sets out how redress agencies will apply the Framework. It ensures consistency, transparency, and survivor-centred decision-making across all agencies. It first discusses some key aspects of the definitions and then provides a step-by-step guide on how to apply the Framework.

2. Definitions and interpretation

This section explains how the definitions and interpretations for different parts of the Framework have been classified. It should be read next to the *Common Payment Framework.*

Types of abuse and severity level

The Framework outlines the types of abuse (Physical abuse, sexual abuse, emotional/psychological abuse, neglect) and examples of where instances may be placed in a table indicating a scale of severity.

Frequency of abuse or neglect

The frequency table is used by agencies to consider how often and for how long abuse was experienced, which is one of the criteria used in the payment categories.

How often?					
Once	Infrequent	N/A			
Sometimes (eg "occasionally", "at times")	Infrequent	Infrequent	Infrequent	Infrequent	Frequent
Often (eg "a lot", "every week", "regularly")	Infrequent	Infrequent	Frequent	Frequent	Chronic
All the time (eg "every day", "always")	Infrequent	Frequent	Frequent	Chronic	Chronic
	0 to 6 months	**More than 6 months and up to 1 year**	**More than 1 year and up to 2 years**	**More than 2 years and up to 4 years**	**More than 4 years**
	How long? (Duration of abusive period[14])				

Practical notes:

- The assessment of the claim will need to consider frequency. Agencies may need to clarify (through steps relevant and reflective of each agency's process) frequency as a measurement in order to apply it to the table.
- The terms under 'how often' are examples of regularity, noting that survivors may use other terms to describe how often their abuse occurred. A level of judgement may be needed as to whether it falls into 'sometimes', 'often' or 'all the time'. If you are unsure, please seek advice from whoever you would normally seek advice from in your agency such as your Team Leader.
- The duration of the abusive period may be for the entire length of a placement, or it may be a period within the placement.

Example

For example, the survivor may have been in a care placement or at a school for three years but alleged that the abuse began 18 months into the care placement or after they started at the school. When determining duration, the 18-month period is considered, rather than the full three years.

Carers and non-state carers or other young people

Carers

For the purpose of applying the Payment categories, carers are agents of the State who have care and protection responsibilities for the survivor. They include:

- Caregivers approved and appointed by the agency which has legal responsibility for the survivor
- Staff of the agency which has legal and/or care responsibilities for the survivor (for example, social workers, teachers, other school staff, hospital staff)
- Staff or caregivers of a non-government agency (NGO) or Iwi Social Service contracted to provide care services on behalf of the State agency which has legal responsibility for the survivor will generally also fall into this category, where the relevant State agency would otherwise have that responsibility.

While the above roles are easily identifiable as 'carers' for the purposes of the Framework, some relationships are less clear and exceptions can exist. While not possible to outline all possible exceptions, the following factors may be relevant in supporting a redress agency to determine responsibility:

- Legal status of the person – Did the State have formal responsibility for the person such as having a custody order in its favour?
- Funding of the placement – Did the State fund the placement?
- The role of the alleged perpetrator
- The State's role with the person in making the placement, and/or monitoring it
- Did the State have a contractual relationship with the alleged abuser?

Example relating to medical professionals working in a care residence

With the exception of cases where the medical professional was an employee of the agency (e.g. the Department of Social Welfare) who ran the care residence where the alleged abuse occurred or contracted to that agency to provide medical services in, medical practitioners will not generally be considered as carers as defined above even when the survivor was under the care, custody or guardianship of the State and placed in a care residence. For example, a doctor providing health services to children in a residence through a Ministry of Health contract or arrangement would not meet the carer definition outlined above.

Non-state carers and other young people

For the purposes of the Framework, **non-state carers** are those who have not been given formal legal responsibility towards the person or recognised as having that role by the State.

Non-state carers can include, but are not limited to:

- The survivor's parents/step-parents
- The children of State approved caregivers
- Family members of state approved caregivers where the caregiver allows them access to the survivor

Other young people refers to other children and young people in state care and who are in the same care, residential, education, health or NGO setting as the survivor.

Practical notes:

- This definition is only applicable if the redress agency's process has recognised abuse and neglect by a non-state carer or other young person that has arisen from, or relates to, the acts or omissions of the carer and has contributed to the abuse by the non-state carer or other young person occurring or continuing.

Example relating to child protection setting
For example, where Social Welfare did not respond (or did not respond adequately) to a report that a child was being abused by their parents in line with legislation or policy of the time. Or where another young person in a residential education facility is able to sexually assault the survivor because there was no staff member available to supervise the children overnight when there should have been such supervision.

For further information about how this concept is assessed, please refer to separate agency specific guidance.

3. Applying the Framework – step-by-step

Applying the Framework involves three main steps:

1. **Classify each allegation** using the definitions.
2. **Map** to the correct payment category and step.
3. **Finalise and record** the payment with clear rationale.

Step 1: Classify allegations

For each allegation acknowledged by the agency confirm:

- **Type of abuse/neglect and severity**
  Use the *Abuse and Neglect Definitions and Examples* in the Framework to determine whether the allegation would come under physical abuse, sexual abuse, emotional/psychological abuse or neglect and whether it is 'less severe', 'more severe' or 'significantly severe'.

  Each type of abuse/neglect definition contains examples of abuse that would fit under the definition and the severity it would be categorised. As these are examples and are not complete lists, they are to help guide an assessment of severity. Where there is no similar example, consider seeking advice from more experienced staff within your agency or checking with other redress agencies in line with any established processes.
- **Who carried it out**
  Determine whether the abuse was carried out by a Carer or non-state carer/other young person in line with the above guidance.
- **Frequency**
  Determine frequency (infrequent, frequent, or chronic) using the *Frequency Matrix* and the above guidance.

Step 2: Map to payment category

- Identify the most serious allegation(s) by identifying those that fall into the highest category and step using the payment categories.
- For the most serious allegations, if there are multiple allegations that have the same severity and abuser, consider whether the frequency changes when the allegations are combined.
- Decide which payment category and step within the payment category that applies.

Example for a psychiatric setting
Three allegations of infrequent (occurred "often") less severe abuse by hospital staff over the following periods (four months in 1971, four months in 1972 and five months in 1974), cover 13 months in total making the most serious allegation to be considered under the Framework as 'frequent less severe abuse'.

Step 3: Finalise and record the payment and rationale

- In accordance with any relevant agency specific template or requirements, set out the rationale for recommending the payment category and step.
- Depending on your agency's approval processes, this information may be included in your internal approval memos/briefings, and a version will also be included in your response to the claimant.

Example
The most serious abuse experienced by the survivor was more severe level physical abuse by a carer which occurred every day over a one-month period. The frequency of the abuse was infrequent (every day and within 0 – 6 months). That fits within category 2, step 1 being a $25,000 payment.

Practical notes:

- There may be rare claims where a discretionary payment should be considered for an amount that sits outside the payment categories, or at a different point within the category than which the claim would ordinarily sit at. Please refer to the separate discretionary payment guidelines for further information.

Summary table

Allegations supported under agency assessment process

All allegations relate to a 2.5 year period at a school

- Sexual assault (touching over clothing) on more than one occasion by a staff member.
- Regular physical assaults (including physical restraint) by staff members. No injury indicated.
- Excessive timeout for extended periods of time and inconsistent with policy guidelines.

Step	Action	Example
1. Classify	Identify type, severity, frequency, and abuser for each allegation.	Sexual abuse = more severe, infrequent (occurred sometimes), carer; Physical abuse = less severe, frequent (often + more than 2 and up to 4 years), carer; Emotional abuse = less severe, infrequent, carer.

Allegations supported under agency assessment process

All allegations relate to a 2.5 year period at a school

- Sexual assault (touching over clothing) on more than one occasion by a staff member.
- Regular physical assaults (including physical restraint) by staff members. No injury indicated.
- Excessive timeout for extended periods of time and inconsistent with policy guidelines.

Step	Action	Example
2. Map	Determine highest category and step.	Most serious allegation = more severe sexual abuse, infrequent, carer → Category 2, Step 1.
3. Finalise	Document rationale	"The most significant abuse was more severe sexual abuse by a carer, infrequent. Category 2, Step 1: $25,000."