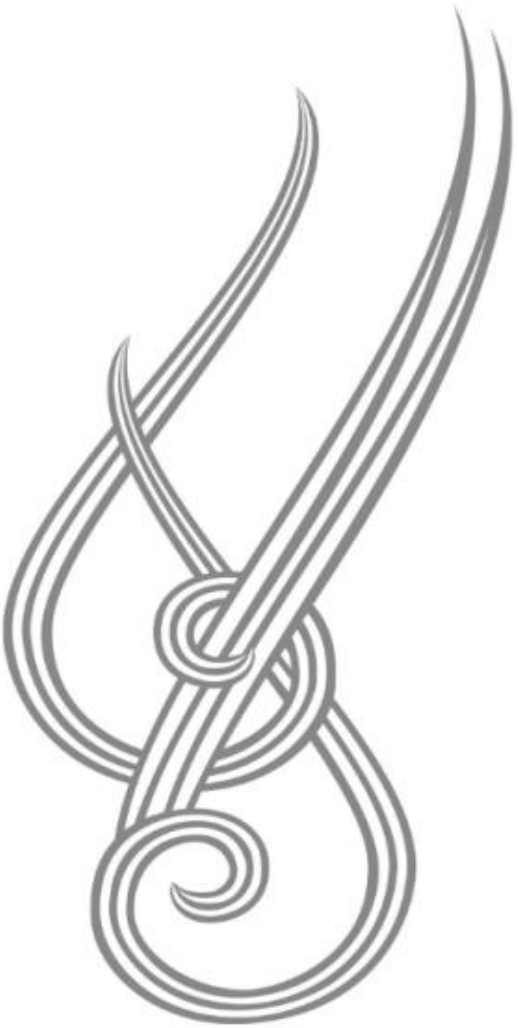
MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

MSD Historic Claims Practice Guidance November 2021



Owner: Linda Hrstich-Meyer

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Assessing frequency

Last review date: October 2021 (new practice guidance)
Approved by: Linda
Owner: General Manager Historic Claims

When considering Historic Claims payment categories and associated guidance, we look to understand a claimant's experience and the seriousness of that experience. This enables us to translate allegations into the payment categories and to be as fair and consistent across claims as possible. Frequency (i.e. the alleged regularity of occurrences of abuse) is an important aspect of this, and one factor that helps us to understand the seriousness of the claimant's reported experience of their time in care or involvement with Child, Youth and Family or its predecessors.

All abuse is unacceptable; both isolated incidents as well as abuse that occurs with higher regularity. The categorisation of frequency is not intended to minimise a person's experience, but rather to support us to apply an objective, consistent and fair approach across claims when considering frequency of alleged abuse.

Frequency levels

There are three levels of frequency relating to how often abuse was alleged to have occurred.

- Acute/Infrequent abuse: Refers to one-off incidents, or other infrequent, low instances and more variable abuse, to the level described (low, moderate or serious). This is days or weeks / months, not years. Where abuse is unspecified it could default as low.
- Frequent/repeated abuse: Refers to abuse that has a pattern of regularity to it, recurrent but not to the level of chronic or prolonged. This can be a high number of months, to several years.
- Chronic/prolonged abuse: Refers to persisting, repetitive or recurring, long-lasting abuse, to the level described (low, moderate or serious). This is a number of years.

Referring solely to a time period does not necessarily reflect the seriousness of the experience in terms of how often abuse is alleged to have occurred during this period. This practice guidance supports us to approach frequency considering both the length of the time period and how often the alleged abuse occurred during the time period. Where ambiguity exists, particularly where it may have a material impact on the outcome of a claim, it is important that we provide opportunity for claimants to clarify their experience.

How frequency may be described by claimants

There are two main ways frequency of alleged abuse is expressed to us by claimants:

- Through a count (e.g. *"twice", "five times", "only once"*)
- Through describing language (e.g. *"happened regularly", "every day", "often", "multiple times", "sometimes"*)

When describing language is used, it is important to factor in the duration of their placement to assess frequency.

"I was regularly beaten for wetting my bed while living with Mr and Mrs X[1]*".* Consider how long the claimant lived with Mr and Mrs X. While the alleged abuse might have happened frequently in that placement, it might <u>not</u> be considered frequent for the purpose of our model when we consider the relative context of their childhood or time in care (e.g. length of placement). The payment framework translates the frequency in the context of their time in care; a higher regularity of abuse over a longer time results in a more significant abuse experience (in relation to frequency). Note that this does not change the abuse *severity*, only the *frequency*.

"I was hit every day, and told I would never amount to anything...an unwanted brat...while I stayed at the Family Home". Consider how long the claimant stayed at the Family Home. There is a difference between being physically abused every day for two weeks <u>vs</u> every day for eight years. We can immediately recognise that these are substantially different experiences. Although the regularity of abuse within each placement was the same, the first scenario would be considered infrequent abuse and the second scenario would be considered chronic abuse, due to the length of the experience.

Examples
• Regularly abused (placement duration was two months) is frequent *in that placement* but infrequent in the relative context of their care experience. • Occasionally abused (placement duration was five years) is infrequent *in that placement* though it could be infrequent or frequent depending on whether it was consistently 'occasional' over that period or on one or two occasions. • Abused every day (placement duration was two weeks) is chronic *in that placement* but infrequent in the relative context of their care experience.

When a claimant uses a count of incidents to express frequency of abuse, judgement will be required. Low numbers could be considered to be infrequent, noting that a claimant is more likely to revert to describing words when the times they were abused was high (e.g. a claimant is unlikely to say *"27 times"*; instead they are likely to say *"multiple"* or *"a lot"* of times).

The table below starts with the language that may be used (on the left-hand column) and considers the frequency indicated in that specific placement, then the duration of the placement is overlaid to understand how frequency should be determined for our model. To reiterate; it may appear frequent *in that placement* but if the placement duration is

[1] These are fictional examples. For the purpose of this practice guidance, surnames of either fictional claimants or alleged perpetrators are not used to prevent a person from incorrectly identifying themselves in drafted examples in the event they coincidentally share the same name.

short, then it becomes infrequent in terms of how the payment framework is constructed.

Guidance for identifying frequency of abuse in the context of care experience						
LANGUAGE USED	FREQUENCY IN THE PLACEMENT		DURATION OF PLACEMENT			
			Low duration (i.e. days/weeks	→		**High duration (i.e. a high number of years)**
Once, sometimes, at times	Acute, Infrequent	→	Infrequent	Infrequent	Infrequent	Infrequent/ Frequent	Infrequent/ Frequent
Regularly, multiple times	Frequent, repeated	→	Infrequent	Infrequent	Infrequent/ Frequent	Frequent	Chronic
All the time, every day, always	Prolonged, chronic	→	Infrequent	Infrequent/ Frequent	Frequent	Chronic	Chronic

Note: This table provides a visual tool to support Claims Assessors to understand the concept of frequency of abuse in the context of care. It does not prescribe outcomes, but supports us to understand how frequency is considered in assessment.

Where there are two options in the box, that is to allow for the specifics of the allegations to be taken into account. After careful consideration, if on balance the allegation could fall into either frequency category because it potentially straddles two definitions, generally it will be appropriate to select the more frequent definition.

The severity of the allegation is also factored in separately to frequency, and therefore the frequency definition on its own does not solely determine the seriousness of the experience.

If frequency is unknown, and the context does not provide a reasonable basis to determine frequency and may have a material impact on the outcome of a claim, consider whether seeking further clarification about this from the claimant would assist.

Determining frequency in this way is not a judgement of the impact of abuse on a claimant. Rather, assessing frequency by considering both the length of placement as well as the regularity of the alleged abuse during this placement supports us to be objective, consistent and fair in our response to claimants.

Approve practice guidance – Assessing frequency

L. A. Hrstich-Meyer

Approve/~~Decline~~

26.10.2021

Linda Hrstich-Meyer

General Manager Historic Claims

Date

Duplicate Allegations

Last review date: October 2021 (new practice guidance)
Approved by: Linda Hrstich-Meyer
Owner: General Manager Historic Claims

This practice guidance supports us to understand how we recognise different experiences and allegations that happen in the same placement or by the same alleged perpetrator. This might be over different stays at the same placement or different types of abuse in that placement. The focus in managing duplicate allegations is to record the concern as accurately as possible, without making assumptions that either minimise nor elevate the claimant's reported experience.

We remain mindful of the difficulties in memory that can exist given the length of time that has often passed for some claimants since their time in care, resulting in specific incidents not being recalled. Additionally, we recognise the dynamic that abuse can be underreported, and barriers may exist that prevent claimants from disclosing some abuse experiences. Where ambiguity exists, particularly where it may have a material impact on the outcome of claim, it is important that we provide opportunity for claimants to clarify their experience so far as they wish to.

Duplicate placement type

It is not unusual for claimants to have multiple placements at the same Family Home, Care and Protection Residence, Youth Justice Residence or other type of placement. In their description of their care experience, claimants may group experiences by placement rather than by individual incidents.

For a claimant placed in Epuni Boys' Home on three separate occasions, they may say *"while I was at Epuni, each time I was given an initiation beating"*. In this example, where the claimant has alleged an initiation beating on *each* occasion of the three stays, although we could group this as one allegation relating to initiation beatings, this has the potential to disadvantage those placed three times in the *same* residence, when compared with a claimant placed in three *different* residences. Given the specificity provided that this occurred at each Epuni placement, these should be considered as three initiation beatings (and no different than if the claimant made an allegation of an initiation beating at three *different* residences). Our focus is on understanding the care experience and reported incidents. The way in which this is reflected in an assessment may differ, though what is important is that the allegation outcome is able to be translated appropriately into any payment rationale.

Where a claimant had multiple admissions to the same placement and hasn't specified during which the abuse occurred, then we cannot assume that it occurred at each admission. In those instances, and where we are unable to ascertain further information from a claimant, this should be treated as one allegation. Where we cannot reach an understanding of which placement the abuse allegation relates to, select one placement to reflect the abuse in, taking care not to either over or underrepresent the alleged abuse (e.g. if a claimant has alleged regular, moderate physical abuse at Epuni during one placement, quantum will be affected by selecting a seven day placement as opposed to a six month placement). Where multiple instances of abuse at a placement is alleged (irrespective of whether the claimant cannot recall specific instances) then these should be assessed as such.

Duplicate abuse type

When a claimant alleges that they experienced more than one abuse *type* in a placement these are identified as separate abuse allegations. A claimant may allege that they were physically and emotionally abused by their foster mother. In this example, we respond to two allegations; physical and emotional abuse.

On the other hand, where more than one abuse type is present *within* an allegation, these will generally be addressed as one allegation, focussed on the primary issue with the other abuse type/s making up the contextual part of the recorded allegation. For further information, please see "*Practice guidance - How to identify and write an allegation*".

Mix of abuse severity

Generally, an allegation of physical abuse is described and categorised as one type of severity; low, moderate, or serious. Where the claimant alleges different severity for the same abuse type, care needs to be taken to how we respond. The following examples provide guidance about how to respond to allegations which have a mix of abuse severity within an allegation.

- Where abuse is described without specific incidents and covers a mix of alleged abuse (e.g. *"Over a 12 month placement I was regularly slapped, pushed, smacked and sometimes punched"*), it is appropriate to categorise these as two distinct severity levels (frequent, low level physical abuse and infrequent, moderate level physical abuse).
- If the claimant alleges being regularly slapped and shoved during a placement (i.e. low-level physical abuse), and states that on one occasion he was seriously physically assaulted with a weapon resulting in hospitalisation (serious physical abuse) it would be appropriate to record two separate allegations to allow for severity to be reflected. It also reflects more accurately the nature of their experience; not all low level abuse, and not all serious abuse.
- It is not unusual for a claimant's description of a singular abuse incident to include layers of severity, such as *"he pushed and shoved me, and then hit me so hard my head hit the wall and I got knocked out"*. Though multiple severity levels are noted in this example, the incident in and of itself is responded to as one serious physical abuse allegation.

Multiple allegations about the same perpetrator

Where a range of examples of the same abuse type and severity are noted by the claimant, it is not necessary to detail each incident of abuse (e.g. *"one day, Mr Jones grabbed me by the scruff of the neck…..then about a month later he shoved me into a wall. Nothing happened for awhile, and then he started doing it basically every time he was drunk which started to be every day….this went on for months"*). These allegations can be grouped together (in this situation as *"frequent, low level physical abuse"*), as the frequency allows for the repetitive nature of the abuse to be reflected.

Approve Practice guidance – Duplicate Allegations

Approve/~~Decline~~

Linda Hrstich-Meyer
General Manager Historic Claims

26.10.2021
Date

Emotional, Psychological and Verbal abuse allegations

Last review date:	October 2021 (new practice guidance)
Approved by:	Linda Hrstich-Meyer
Owner:	General Manager Historic Claims

Emotional abuse is the collective term that also includes variations of psychological and verbal abuse. It will be in the allegation description that the variation will be documented, but for the purpose of recording, this type of allegation is recorded as emotional.[1]

Emotional abuse when it accompanies other types of abuse

We accept that emotional abuse is a likely partner to most abuse experienced, so it is not required that you list a separate emotional abuse allegation when it accompanies other forms of abuse. For example, where verbal abuse escalates to physical abuse, the verbal abuse is not recorded as a separate allegation of emotional abuse, though it is can be reflected in the allegation description. Where emotional abuse is present by nature of the physical or sexual abuse alleged, the emotional abuse does not need to be documented separately; it forms the contextual part of the allegation.

Severity of emotional abuse

We generally do not differentiate between low, moderate or serious emotional abuse. Emotional abuse severity is difficult to determine without a psychological assessment, as it is often in its long-term impact that the seriousness is realised.

There are however situations where the severity of the emotional abuse will need to be defined, including:

- in situations where the severity of the abuse is so significant that a Category 4 payment or above would be recommended if taken into account (e.g. being forced to watch a sibling being sexually abused by a caregiver over a prolonged period).

Routinely emotional abuse will be recorded as 'Not applicable' (to reflect that we generally do not differentiate severity) unless, on its own, the seriousness is such that it requires assessing as moderate/chronic or serious. These should be considered on a case-by-case basis and will likely be 'exceptions', with a clear rationale outlining the basis for the increased severity.

Where consideration is being given to whether an allegation of emotional abuse should be assessed as an exception, advice can be sought from Team Leader and/or the Lead/Senior Claims Advisors to support a consistent threshold to this being applied.

Step 2's and emotional abuse

[1] This is consistent with the interchangeable use of terms in social sector research

When it is evident that the emotional abuse allegation is an exception (moderate/chronic or serious) consideration will need to be given to whether a Step 2 may be required.

- For Responsible Adult abuse allegations, a Step 2 is required if the abuse is so significant that if taken into account it would justify a Category 4 payment or above.
- When considering 'Inaction contributing to emotional abuse' the inaction matrix in the definition sheet can be used to guide when a Step 2 is required. For most emotional abuse allegations being recorded as 'low' they will generally reach either low or medium levels of inaction and therefore will not require a Step 2. When it is evident that the emotional abuse allegation is an exception then refer to the inaction matrix to determine if the emotional abuse represents high levels of inaction in which case a Step 2 will be completed.

Approve practice guidance – Emotional, Psychological and Verbal abuse allegations

Approve/~~Decline~~

L. L. Hrstich-Meyer

Linda Hrstich-Meyer

General Manager Historic Claims

26.10.2021

Date

How to identify and write an allegation

Last review date: October 2021 (new practice guidance)
Approved by: Linda Hrstich-Meyer
Owner: General Manager Historic Claims

Understanding a claimant's concerns and identifying allegations is fundamental to ensuring that we are responding appropriately to a claim, and addressing a claimant's concerns. A claimant's account of their childhood may involve a range of experiences; some of which purely form part of their story or narrative about their childhood, and some of which will form the basis of their claim.

Claimants are not expected to share their experience in a way which neatly forms allegations; our job is to understand the issues and record these in a way that accurately reflects the claimant's concern and ensures that the Historic Claims process can respond to it. Where ambiguity exists, it is important that we provide opportunity for claimants to clarify their concern.

What is an allegation?

An allegation is an issue or event identified by the claimant while involved with Child, Youth and Family or its predecessors, that they want addressed and acknowledged in some way. This may be in relation to abuse or practice failures.

Identifying allegations

Prior to starting an assessment:

- Review the relevant sources that will help identify the claimant's concerns (i.e. listen to the interview audio recording, review the initial referral and all relevant file notes and emails in the claimant's EDRMS file, review Letter of Offer and Statement of Claim as relevant). It is important to review all relevant documents to ensure that all allegations are captured.
- Take note of any questions or areas of significance to the claimant. This allows us to gather information from the claimant's records to be able to respond to their questions, as well as note areas of significance to them.
- Ensure that the identified allegations recorded in the Historic Claims Application are consistent with those in the source documents before beginning an assessment.

If further information is required from the claimant in order to understand their concerns prior to beginning an assessment, consider whether a further discussion with Claimant Support may assist (for direct claimants), or whether clarification can be sought through the claimant's representative. Note that any contact with a claimant's lawyer must be made through appropriate channels, and not made directly by a Claims Assessor.

Writing an allegation of abuse

The allegation should clearly describe what the claimant says happened. Historic Claims recognises that claimants may not always be able to recall specific details of an incident of abuse. Though where the information has been provided, the allegation description should include:

Detail to include (where available)	E.g.
Who	The name and role/relationship of the alleged perpetrator. If the full name was provided by the claimant, refer to the name by first and last name (as opposed to using "*Mr*" or "*Mrs*").
Where	The residence, Family Home, placement or relevant location
What and how often	A description of what happened (e.g. *hit across the head on two occasions*). Be specific, and where possible, the claimant's words should be used in the description. If the claimant has described an assault as having been bashed, use the word *"bashed"* in quote marks. Any descriptor words about abuse should be from the claimant's language, with quote marks. Similarly, short, relevant, descriptions provided by the claimant can be used (e.g. That the foster mother *"started beating me all the time"*, hit him with *"a wooden spoon... anywhere she could... I remember her breaking it over my arm once"*).
When	This may be articulated by the claimant by age (*e.g. when he was eight*) or the context (e.g. *after a football match*)
Why	There may be context provided by the claimant about why the event took place (e.g. *because he talked back to the caregiver*)
Examples of abuse allegations	
• Kevin has alleged that his Family Home caregiver, Mrs P[1], "whacked" him over the head on a number of occasions. • Sarah recalls two instances where a staff member at Kingslea sexually assaulted her. She cannot recall his name. "He would come into my room after lights out...I remember his hand over my mouth...the first time he made me get him off, but the second time he raped me". • That when she was eight, Te Aroha's caregiver, Mr H, would scream at her "all the time...for nothing....he called me useless, a cow and told me that's why my parents wouldn't want me back".	

Full passages taken from a claimant's lawyer or an interview transcript are not required. The relevant information is lifted from the claimant's account to develop a statement (allegation) that accurately reflects their concern in a way that Historic Claims can respond to.

[1] These are fictional examples. For the purpose of this practice guidance, surnames of either fictional claimants or alleged perpetrators will not be used to prevent a person from incorrectly identifying themselves in drafted examples in the event they coincidentally share the same name.

Writing a practice failure allegation (inaction and inadequate practice)

Claimants are unlikely to reference *"practice failure"* during their own account of their experience. This is Historic Claims language. Though this term may be more commonly referenced in Letters of Offer for legally represented claimants.

Claimants may talk about something that did happen (e.g. *"I told my social worker that Mr J had hit me – she left me in that placement and never did anything about it"*) or did not happen (e.g. *"I was in that placement for years – no one ever came to check on me"*). Where noted by the claimant, record any abuse consequence they have identified as a result of the failure, as this assists to determine whether an allegation is assessed as inaction.

Examples of practice failure allegations
• That Mavis spent three nights in the secure unit at Weymouth. She only had one meal during that time. • Tamati told his social worker when she visited once that his caregiver had kicked him. He remembers that social worker saying "that's no good", but she never did anything more about it. Tamati says that the abuse did not stop, and actually got worse. • Jenna cannot recall any social worker visiting her while she was placed at family/whanau caregivers Mr and Mrs F's home. She was there for around four years. "I think someone came once and met with Auntie.....but they never talked to me...".

We will then define this as an alleged practice failure (either as inaction or inadequate practice, depending on whether the failure contributed to alleged abuse) for the purpose of our assessment.

Statements which are not allegations

Statements made by the claimant about the care they received while in their home and before coming into care are part of their story or narrative, and not an allegation (unless they are clearly stating there was some fault on the part of Child, Youth and Family or its predecessor). For example *"Living at home was hell – it was like Once Were Warriors"* is not an allegation. Though *"Living at home was hell – it was like Once Were Warriors. There were social workers always visiting but they never did anything"* is an allegation.

Not recording this as an allegation does not prevent us from identifying failures ourselves through the course of assessing a claim.

Claimants may also have questions about decisions that were made about their time in care or involvement with Social Welfare. Unless the claimant raises a concern about the particular decision, or the issue is the subject of a noted allegation through the course of an assessment, these questions are considered for the purpose of supporting claimants to understand their care experience, and are not considered to be allegations.

Addressing multiple allegations about one situation

Sometimes claimants will make multiple allegations in one statement, such as *"He was placed in secure in inappropriate conditions, without adequate cause"*. These are two different allegations; one of inappropriate conditions and one that he should not have been placed in secure (i.e. a breach of policy/regulations). These will be responded to separately and have two separate outcomes (as they relate to two different issues). For

further information about how to respond to multiple allegations made about one placement or alleged perpetrator, please see *"Practice guidance – Duplicate Allegations"*.

Where there is more than one abuse type as part of an allegation

Emotional abuse is a likely partner to most abuse experienced. An incident may involve verbal abuse (as a form of emotional abuse) escalating to physical abuse (e.g. *"The caregiver called me a bitch, dragged me across the room and slammed me into the wall"*). The verbal abuse is not recorded as a separate allegation. This would generally be addressed as an allegation of physical abuse. Where emotional abuse occurs in the context of physical or sexual abuse, the emotional aspects do not need to be documented separately – they make up the contextual part of the recorded allegation. For further information, please see *"Practice guidance – Emotional, psychological and verbal abuse allegations"*.

Similarly, where a claimant states that in the course of being sexually assaulted they were also hit, the type of abuse assessed is the primary allegation, which we ideally have an understanding of from the claimant's description of the event. The focus is on acknowledging the incident, as opposed to trying to break it down into component pieces.

There may be small numbers of exceptions which require case-by-case consideration. Such a situation may, for example, be where in the course of being sexually assaulted the claimant suffered a serious physical injury from a physical assault during the alleged abuse incident. It may be appropriate in such a case to separate out both types of assault for the purpose of assessment, and respond to each separately.

Addressing non-specific allegations

Addressing allegations where the claimant has spoken in a non-specific way about a number of things happening over a number of placements can be challenging.

"I went into Weymouth about three different times and always got the bash from staff". Without further specific details from the claimant, this would be recorded as one allegation, though if records confirm three placements, we can note that this is alleged to have occurred over three placements.

Similarly, if the claimant says *"I went into Weymouth and got the bash from Mr S, Mr B and Mr J"*, then in the absence of further details and lack of specificity about the nature of the individual assaults, this also would be recorded as one allegation, as opposed to three separate allegations of three separate perpetrators.

In both of these types of non-specific allegations, the claimant's reported experience still needs to be considered in the claim assessment (e.g. alleged abuse by multiple staff at Weymouth). What is important is that the allegation outcome is able to be translated appropriately into any payment rationale.

If the claimant states *"Once, one of the staff members even raped me"*, this would be a separate allegation. One allegation in relation to the non-specific physical abuse over the three placements, and one specific allegation of serious sexual abuse.

Multiple placements, with clearly defined abuse at each placement

If the claimant is clear about specific instances of abuse in multiple placements at the same Family Home/residence/foster placement, these should be treated as separate

allegations. Each may have their own specific details and circumstances and depending on severity may require different assessment thresholds.

Letters of Offer – represented claimants

Represented claims will typically involve receiving a Letter of Offer (as well as a Statement of Claim when the claim is filed in court). These are often lengthy in nature, as it is the claimant's opportunity, via their lawyer, to share their care experience and these will often refer to the claimant's social work records in detail. Letters of Offer may include lengthy passages which refers to the claimant's journey through care as noted in the social work records, as well as noting concerns. This can make it challenging to identify what the concerns are, and require care to ensure that we are responding to the claimant's concern about what MSD is responsible for.

For example, the comment *"It is unclear why his court status was revoked"* is not an allegation in and of itself. Though, if the context surrounding that statement involves concerns about this decision or articulates a consequence for the claimant, then this would be identified as an allegation.

Letters of Offer do not always provide the claimant's own words, but it will include their experience, as shared with their lawyer. Judgement is needed in how language from a Letter of Offer reflects the claimant's concern. The full passage is not required.

Rather, consider the core components of the passage, to separate out specific allegations to respond to, and those which can be grouped together as a theme of abuse or failure. Where a number of comments relating to a similar theme are identified (e.g. a number of notifications not adequately responded to), it may be suitable to collapse these into one practice failure (e.g. *"On a number of occasions between 1992 and 1995, CYFS failed to adequately follow up reports of concerns in relation to Dillon's safety in his parents care. This included concerns about physical abuse and exposure to gang and drug activity in the home"*).

Noting abuse or practice failures <u>not alleged by the claimant</u>

In the course of assessing a claim, the Claims Assessor may identify from the records incidents of abuse or practice failures which the claimant has not talked about. It is correct to add these as additional instances of abuse or practice failures, though clearly recording that these have been identified by the Claims Assessor through the course of assessment. A Step 2 analysis is only required if the nature of the identified issue meets the usual criteria for requiring this higher assessment threshold. Sufficient detail should be provided to identify the information that has led to a noted practice failure or abuse allegation. For noted practice failures, relevant policy and practice standards that have not been met should be identified.

Approve practice guidance – How to identify and write an allegation

Approve/~~Decline~~

L. L. Hrstich-Meyer

Linda Hrstich-Meyer
General Manager Historic Claims

26.10.2021

Date

How to prepare a Step 2 analysis

Last review date: October 2021 (new practice guidance)
Approved by: Linda Hrstich-Meyer
Owner: General Manager Historic Claims

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 for a Step 2 analysis, as outlined below;
- 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 no factors that indicate it may appropriate for the claim to be reviewed.
- information has been identified in the assessment that points against the allegation[1].

Where allegations are of a more serious nature, a Step 2 analysis is required to provide increased rigour around the assessment of these allegations. This enables the Ministry to have a better understanding of the more serious abuse alleged by those who were in care and provides confidence 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.

Allegations against a responsible adult that involve any of the following require a step 2 analysis:

- moderate (chronic) physical abuse;
- serious physical abuse; and
- moderate and serious sexual abuse.

A step 2 is also required:

- when high levels of inaction are alleged or identified;
- where there is a potential BORA breach or potential false imprisonment, both of which may constitute a higher level of payment; and

The *Definitions sheet* in the Historic Claims Handbook provides further guidance on how to determine whether or not an allegation fits within these criteria.

The types of additional information that may be considered includes:

- other claims made against the alleged abuser;

[1] Refer to MSD Historic Claims Business Process and Guidance for additional guidance on information that may point against an allegation.

- 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;
- other relevant information.
-

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 staff member, caregiver or institution. This may include consideration of other allegations received or documentary information held by MSD
- whether descriptions, modus operandi described align with other known allegations; or
- the certainty of other similar allegations (e.g. criminal convictions or complaints made and investigated at the time).

The information contained in the Step 2 analysis will depend on the nature of the allegation and the available information considered as part of an assessment. A Step 2 analysis requires 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. This is a different threshold to that applied to an allegation that does not meet the criteria for a Step 2.

Where generally allegations are taken into account unless there is information that points against allegation, the focus of a Step 2 analysis is to consider whether there is information that supports the allegation. Note that despite supporting information being required when a Step 2 assessment is completed, proof to the standard of what a court would need (i.e. the balance of probabilities) is not required.

How to prepare a Step 2 analysis

After noting the allegation, the Step 2 should clearly set out all the facts relevant to the allegation that have been identified in your research, and the analysis section should lead the reader through a logical consideration of those facts that leads to a well informed and well-articulated conclusion. It should be clear and evident to the reader what information has been considered in the assessment, and demonstrate how the Claims Assessor reached that conclusion[2].

While each Step 2 is set out depending on the nature of the claim and available information, the below illustrates the type of information which is useful to include:

Section	Type of detail to include
Allegation	A clear description of the issue or event identified by the claimant (or by the Claims Assessor during a review of records). Refer to *"Practice guidance – How to identity and write an allegation"* for further guidance.

[2] Note that this document is prepared to provide guidance about content only. The structure of a Step 2 analysis will be incorporated into existing assessment documentation as required.

Facts	• Relevant placement dates • Status • Set out any relevant policy requirement and/or legislation that relates to the allegation, based on the relevant time period. *For allegations of abuse* • Confirmation that an alleged abuser was employed at the relevant placement / confirmed as a caregiver. • Information in records which confirms an investigation about the allegation at the time, and the outcome of this investigation. • Records which provide details relevant to the allegation (e.g. disclosure of abuse at the time). • Other allegations of the same nature made by other claimants. Where the alleged abuser is named, for each similar allegation made against that person you should record: ❖ the allegation as described by the claimant ❖ what threshold the claim was assessed under (e.g. brief assessment such as the Ministry's Two Path Approach, comprehensive) as well as the outcome and brief explanation of the assessment. These factors make a difference to how the information is weighed up. • Where the alleged abuser is not named, identify other similar allegations relating to the same place and time period and record similar information as above. • Regardless of how past claims outcomes have been reflected in past documents, in a claim assessment the wording used should be "taken into account/not taken into account for the purpose of settlement". *For inaction* • Factual details from the claimant's records which are relevant to the nature of the inaction (e.g. if the allegation relates to a lack of visits from a social worker, document the dates evident in records of any social work visits). • Information from records about the alleged abuse the inaction contributed to.
Analysis	The analysis is where you show your thinking, based on the relevant facts available and references the additional information you have considered when forming your conclusion. Think about how strong the factual information is, and identify the factors which you have balanced against each other when reaching your conclusion. The analysis should generally not introduce new factual information. It is important to be clear about what is factual information and what is opinion. Opinion has its place in analysis, though it must be based on available factual information (i.e. records). The analysis outlines the basis for how you have reached the conclusion; it should be objective, and assumptions should be avoided. *Responding to high levels of inaction* In order to determine if there was inaction, insufficient action or inappropriate action that contributed to abuse, then the Step 2 analysis must focus on two factors; any failure on the part of a responsible adult, and whether alleged abuse

	occurred or continued as a result of that failure. The assessment must address both of those areas. When considering the seriousness of the inaction, the duration of the abuse considered can only commence from the time of the failure.
Conclusion	Clearly articulate your position that "Based on the above analysis, I recommend that this allegation is / is not taken into account for the purposes of settlement".

Structuring a Step 2

Generally, the above structure of allegation, facts, analysis and conclusion will support you to logically lay out your assessment. In some instances, the use of sub-headers and bullet points can help to structure a Step 2 analysis. Use your judgement in determining whether a piece of information fits better within the facts or analysis section.

Focus on the specific allegation that the Step 2 is being completed for, rather than the entire care experience. Generally, only one allegation is responded to within a Step 2 but there may be cases where the same information is being used to support multiple allegations and therefore it may make sense to only carry out one Step 2 assessment (though clearly reflecting the conclusion drawn about each allegation). Include only information which is relevant and contributes to the assessment of that specific allegation.

You are aiming to strike the balance in providing the relevant information that supports the reader to understand how you reached your conclusion, while avoiding details of the claimant's care journey that are not relevant to that particular allegation.

Referencing sources

In preparing to assess a Step 2 allegation, consider the types of records that are necessary to search for and review. Where staff members or caregivers are named, ensure a file search is carried out to identify whether files exist for them. Likewise, for files specific to a residence, Family Home, NGO or other placement.

It is then important to show in your assessment what available sources you have checked (e.g. Historic Claims Application, EDRMS, TRIM and/or printed CYRAS record) and reference when a piece of information is being relied on in your assessment.

Where identifying a lack of supporting information, instead of *"Historic Claims has not received...."* note that this is *"at the time of the assessment"*, or *"based on the writer's search of the "x" records"*, as new information is received by Historic Claims every day.

Refer to *"Practice guidance – Information sources for assessment"* for guidance on information sources that can be accessed by Historic Claims which will support your Step 2 analysis.

Reaching a lower severity level than the claimant's allegation

Where a Step 2 has been completed, and insufficient information exists to take into account a particularly serious event, but information does exist to take into account some degree of abuse or inaction, it is appropriate to reach a lower severity in your conclusion. This is still prepared as a Step 2 analysis; the only difference being that the outcome is a lower severity (Example one below illustrates this).

"Neutral" information in an assessment

While some information may act to support an allegation (e.g. other claims made against the alleged abuser), and some information may act to point against an allegation (e.g. clear information that a named staff member or caregiver was not present at the time of the alleged abuse), some information is "neutral"; that is, it neither supports nor disputes a particular allegation.

A lack of supporting information does not act to point against an allegation; it purely means that insufficient information exists to take an allegation into account for the purposes of settlement.

Legal advice

Where legal advice has been sought in relation to a potential BORA breach or other legal issue, reflect this legal advice succinctly and clearly in your analysis. This is a good example of where a sub-header may assist in how the Step 2 analysis is structured.

Examples: Three examples are provided below. Note that every allegation is different, and the facts and information known in any particular case may require a more or less extensive document.

Example one: STEP 2 ANALYSIS OF AN ALLEGATION OF ABUSE – TAKEN INTO ACCOUNT

Allegation

Brendan has alleged that while placed at Hamilton Boys Home, staff member Mr P[3] kicked him until he was *"black and blue"* every day. Brendan recalls on two occasions *"coming to"* after two particularly bad assaults, and believes that he was knocked unconscious on these occasions.

Facts

- Records confirm that Brendan was placed at Hamilton Boys Home from 1 August 1978 to 8 September 1978 (five weeks duration).
- During that time he was remanded in the custody of the Director-General under section 43(1) of the Children and Young Persons Act, 1974.
- Institutional records of the home confirm that Mr P was employed as a staff member during this period.
- Three other claimants (Mr A, Mr B and Mr C) have made allegations of physical abuse against the alleged perpetrator, Mr P.
    - Mr A alleged that Mr P *"hit and smacked"* him regularly during a two month placement. This claim was assessed under the Ministry's Two Path Approach, and the allegation was taken into account for the purposes of settlement.
    - Mr B alleged that Mr P hit him on one occasion during his placement at Hamilton Boys' Home. This claim was assessed under the Ministry's Two Path Approach, and the allegation was taken into account for the purposes of settlement.
    - Mr C alleged that on several occasions during his placement at Hamilton Boys' Home, he was physically assaulted by a staff member, described as *"pushing, shoving and hitting"*. This allegation was assessed under a detailed assessment, which concluded to a reasonable degree of certainty that the alleged staff member was Mr P. The conclusion of the

[3] These are fictional examples. For the purpose of this practice guidance, surnames of either fictional claimants or alleged perpetrators are not used to prevent a person from incorrectly identifying themselves in drafted examples in the event they coincidentally share the same name.

assessment was that it was reasonable to take this allegation into account.

- A file note, dated 6 August 1978, refers to a phone call from Brendan's mother to his field social worker, which noted *"Brandan's mother called. Worried about him. He isn't happy at the Boys' Home"*.
- A file note, dated 4 November 1978, refers to a conversation between Brendan and his social worker, who noted *"I asked him about his time at Hamilton Boys...he doesn't want to go back there, but he wouldn't tell me why"*.

Analysis

Records confirm that the alleged perpetrator was present at the time of Brendan's placement, and has been the subject of three other allegations, though these claimants did not allege abuse as serious as what Brendan does. Records also indicate that on two occasions, Brendan expressed some form of unhappiness in his placement, which may indicate that he was subjected to mistreatment there.

It is reasonable to conclude for the purposes of settlement, based on the information gathered, that Brendan was subjected to physical abuse by Mr P. However, there is insufficient information to conclude the serious level of abuse that took place as described by Brendan.

Conclusion

Based on the above analysis, I recommend that moderate physical abuse over a five week placement is taken into account for the purposes of settlement.

Example two: STEP 2 ANALYSIS OF AN ALLEGATION OF ABUSE – NOT TAKEN INTO ACCOUNT

Allegation

Kelly has alleged that she was raped by a staff member at Weymouth. She cannot recall his name but described him as *"a big guy.....with facial hair, and smelt really bad"*. She said that this happened when she was placed in secure.

Facts

- Records show that Kelly was in Weymouth for a 4 month period (4 March 1986 – 6 July 1986). She was under a guardianship order.
- Secure records confirm that Kelly spent a total of three days in secure on two occasions (one night on 6 March 1986, and two nights from 5 June – 6 June 1986).
- A review of EDRMS folder *"Weymouth Girls Home later known as Northern Residential Centre"* has not identified any other allegations of sexual abuse during 1986 or the surrounding years.
- A review of allegations in the Application has identified three allegations of sexual abuse against named staff members.
- I have confirmed from a TRIM search of these staff member's HR files that two of these staff members were not employed at the time of Kelly's placement at Weymouth.
- One staff member was, and a picture of his driver's licence on file show him to be a large person with facial hair. The allegation made in relation to this staff member was not taken into account for the purpose of settlement due to insufficient information, and also related to a serious sexual assault of a young person in secure.

Analysis

Some information found may indicate that Kelly's alleged perpetrator was the same alleged perpetrator as another claimant has made an allegation about. However, it is not possible to

confirm this and with no available information on Kelly's personal records about this alleged assault, this available information is insufficient to take this allegation into account.

Conclusion

Based on the above analysis, I recommend that this allegation is not taken into account for the purposes of settlement.

Example three: STEP 2 ANALYSIS OF HIGH LEVELS OF INACTION - TAKEN INTO ACCOUNT

Allegation

Joshua has stated that during his time in care, there was a period of four months where he was essentially living on the streets *"I was a ratbag….I took off from Kingslea and I thought that no one really knew where I was"*. Joshua has recently received his records, and believes that his social worker knew that he was living with a man who was a known sex offender during this time, though some of the information on file has been blacked out. He states *"the guy was messing with me from the minute I got there……he gave me drugs and had sex with me….I was so out of it I didn't really know what was happening…I never realised DSW knew I was there with him"*.

Facts

- Records confirm that Joshua absconded from Kingslea during an off site visit on 8 November 1982. He was located by Police in May 1984 after offending, and was placed back at Kingslea. During this period, Joshua was the subject of a guardianship order.
- Records show that initial attempts were made to locate Joshua, including; reporting him missing to the Police (9 November 1982), searching known spots in the town centre where runaways were known to congregate (on 12 and 15 November 1982), and checking with Joshua's parents and several friends about whether he had made contact with them.
- There are no records for an 18 month period from 15 November 1982 until 8 May 1984, when a social work file note states *"I saw Mike (*Joshua's friend*) in passing, and asked if he knew where he was staying at….he said Joshua had been at Mr X's home but was unsure whether he was still there. Note to supervisor – Mr X's children were removed from him years back….sexual offending. Can we please discuss in supervision. Police might be interested too"*.
- There is no information available in records to reflect any further action taken until May 1984 when Joshua was readmitted to Kingslea as a result of offending.
- A supervision note, dated 16 May 1984, notes *"Fiona. As discussed – allocated to you. Key worker on long term sick leave. Please pick up in her absence. You will need to see Joshua at Kingslea. Please update court report for review date in June"*.
- I have confirmed, from a review of Mr X's children's records, that they were removed from his care in 1975 after he sexually abused them. No information is available as to whether Mr X was criminally prosecuted.

Analysis

Records confirm that DSW were on notice from 8 January 1983 that Joshua had been (and may have still been) staying with Mr X, who was known to the social worker as a person of concern. Although records show an initial plan to consult with supervisor to determine a way forward, there is no information in records of follow up in relation to this matter. Contextually, from records, it is possible that the social worker's sick leave may have resulted in this issue failing to be managed.

Joshua has alleged being sexually assaulted by this person, and there is available information to support this allegation, based on Mr X's documented history of sexual abuse against his own children with DSW.

Joshua was a ward of the state at the time, and although he essentially "placed himself" with the alleged perpetrator, DSW were responsible for responding to the identified risk when they received information relating to him staying with Mr X. As above, there is no record that there was any substantive investigation or response. Such a failure constitutes a practice failure.

Conclusion

Based on the above analysis, I recommend that high levels of inaction is taken into account, to reflect what the documents indicate as DSWs failure in following up concerns about Joshua's safety which contributed to ongoing serious sexual abuse over an 18 month period from 8 January 1983 to May 1984.

Approve practice guidance – How to prepare a Step 2 analysis

Approve/~~Decline~~

L. Hrstich-Mg

Linda Hrstich-Meyer

General Manager Historic Claims

26.10.2021

Date

How to write a recommendation for payment

Last review date:	October 2021 (new practice guidance)
Approved by:	Linda Hrstich-Meyer
Owner:	General Manager Historic Claims

Payment recommendations

Recommendations for payment are an important part of a claims assessment in that they record the reasons for why a proposed payment is recommended. They also assist the Consistency Panel in understanding the core components of the claim, the severity of allegations within the claim and why you consider a claim falls within a particular payment category. This is particularly important for lengthy claims where there may be many allegations that are being taken into account but it will not always be automatically clear from looking at the summary of the allegations what payment category the claim would naturally fit into.

More allegations or number of failures do not necessarily mean a higher payment.

A recommendation for payment should clearly document why the Claims Assessor is recommending the claim sits within a particular payment category and any reasons for why it should be placed in the low or high range within the category. This is a nuanced exercise which should focus on the totality of the claimant's care experience that the assessment has taken into account rather than how many allegations of abuse or inaction or inadequate practice there have been.

Factors to consider when writing a recommendation for payment

Before Claims Assessors start writing a recommendation, it may be helpful to consider:

- What are the most serious allegation(s) that are being taken into account? Thinking about the wording of the categories, consider what category these allegations naturally fall into.

- The guidance section in the payment categories. For example, the guidance in category 3 is helpful in understanding the primary factors that need to be present in the band as well as understanding what claims will never fall into category 3.

  The use of AND/OR identifies the primary factors that are present in a band. From Category 3 and above, abuse by responsible adult and inaction are drivers for recommending that payment…… Inadequate practice may also be present…..but on its own would not likely reach a Category 3 or higher payment.

- Whether there are any reasons why a midpoint is not appropriate (i.e. are there any reasons that the claim should be placed lower or higher in the category)

  Examples of why a claim might be placed lower in the category include:

  - The abuse or inaction may have been isolated occurrences or for a short period of time; or
  - Other than the primary allegations, there may be limited other allegations within scope.

  Examples of why a claim might be placed higher in the category include:

  - The abuse or inaction was particularly severe and/or was particularly harmful (but does not meet the criteria for being placed in the next category up);
  - The abuse/inaction was over a lengthy period of time (this can be cumulative abuse in multiple placements); or
  - As well as abuse/inaction, there are wide-ranging practice failures (though not all cases that have wide-ranging practice failures will be placed high in the category).

- Ordinarily, recommended payments should be the exact low-point, mid-point or high-point of the category unless there are good reasons for a different amount (such as to recognise where siblings may have had slightly different care experiences). This helps to ensure consistency between claims, but also acknowledges that for the occasional claim, there may be good reason for a slightly more nuanced payment.

How to write a recommendation

There is no 'one way' to write a recommendation for payment. Though it is important that any recommendation highlights the key components of the claim that fall into the category that is being recommended. For example, most category 3 claims would either contain moderate abuse and/or medium levels of inaction. It can be helpful to underline or italicise these key components in the payment rationale.

It is also a helpful place to highlight the total length of cumulative abuse in multiple placements, which is sometimes not evident in a Summary of Allegations section. For example, mentioning that a claimant was subjected to regular, moderate physical abuse in three placements over a 10-year period is more helpful for the Consistency Panel to understand than just understanding that there were three placements where moderate physical abuse occurred.

There is no need to reference every allegation that is being taken into account, especially where these allegations do not materially impact upon payment. Often there will be a way to summarise these. There is also no need to write statements such as *1 x moderate physical abuse and 2 x minor practice failures*. These types of statements are not of themselves reasons for why a claim should be placed in a particular payment category.

If a low or high range in the category is being recommended, your rationale for this needs to be included.

The easiest way to learn how to write a recommendation is to consider examples. Below are some that might assist.

PROPOSED PAYMENT CATEGORY	PAYMENT RATIONALE
Cat 2 – Mid $10,000	Mr A alleges low-level physical abuse by a responsible adult on three discrete occasions. Further, multiple practice failures exist over a three-year period where DSW failed to adequately respond to Mr A's presenting needs of alcohol and drug abuse, potential harmful sexual activity, sexual abuse and mental health. Minor and peripheral practice failures also contribute to the full picture of Mr A's claim.

PROPOSED PAYMENT CATEGORY	PAYMENT RATIONALE
Cat 3 – Low $16,000	Mr B alleges a mix of low and moderate physical abuse by responsible adults at two placements. One of these placements was a three-month period at Whakapakari where the abuse was at the higher end of moderate abuse, resulting in injuries. Mr B was also subjected to psychological abuse and neglect at this placement. The other placement was only two weeks in length. Low levels of inaction are also present, contributing to moderate physical abuse by the adult children of CYFS caregivers, and resident-to-resident violence while at Whakapakari. Multiple practice failures have been found in relation to social work engagement, planning and actions taken over a two-year period. Although a mix of low and moderate abuse exists, it was infrequent and over reasonably short placements and the identified inaction was low level. On this basis, a low range payment within Category 3 is recommended.

PROPOSED PAYMENT CATEGORY	PAYMENT RATIONALE
Cat 4 – Mid $30,000	Mr C alleges moderate chronic physical abuse by responsible adult for a three-year period when he was still a young child (aged 3-6) and then a further 17 months of moderate physical abuse by responsible adult. During both of these placements, there were multiple practice failures as CYFS

	failed to adequately respond to concerns and disclosures of abuse. In addition, there are wide-ranging practice failures over a 9 year period involving multiple placements and a number of staff members.

PROPOSED PAYMENT CATEGORY	PAYMENT RATIONALE
Cat 5 – Mid $40,000	High level inaction has been identified which has contributed to Mr D suffering serious and moderate chronic physical abuse and emotional abuse from his mother for a four-year period when he was young and vulnerable (ages 2-6). Not only did DSW fail to take appropriate action over this period of time after numerous notifications, but they continued to return Mr D home to his mother's care throughout his childhood where he continued to be physically assaulted and emotionally abused. DSW also failed to take appropriate action during these periods. Medium level inaction has also been identified contributing to Mr D being seriously sexually abused by his whanau caregiver (aged 12, infrequent (4months)). DSW failed to carry out a caregiver assessment prior to placement despite there being known concerns about violence and lifestyle. During the placement, DSW also failed to adequately respond to reports that D was displaying harmful sexual behaviours at school while in the placement. There are wide-ranging practice failures from the age of 1 to 17 with common themes of failing to adequately investigate or take action, failing to adequately monitor or provide Mr D with the supports he needed.

Approve practice guidance – How to write a recommendation for payment

Approve/~~Decline~~

L.A. Hrstich-Meyer

Linda Hrstich-Meyer
General Manager Historic Claims

26.10.2021

Date

Information sources for assessment

Last review date: October 2021 (new practice guidance)

Approved by: Linda Hrstich-Meyer

Owner: General Manager Historic Claims

Under the Historic Claims process, the assessment of most allegations included in a claim will be made based on the information held in the personal/family files (including downloaded CYRAS records where available) with consideration given to relevant legislation, policy or practice manuals of the time. An allegation will be taken into account for the purposes of recommending a settlement offer, unless information is identified in the assessment that points against it from the records reviewed.

It is not necessary to identify information which supports an allegation in order for that allegation to be taken into account. Further, given the difficulties of memory and the length of time that some claimants wait before bringing a claim, a misidentification of an alleged perpetrator does not automatically point against an allegation.

A step 2 analysis (refer to Historic Claims Handbook) requires 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. That analysis involves accessing and reviewing a wider range of records and available information in addition to personal and family files.

The following table provides guidance to the type of records that can be searched for the purpose of assessing a Step 2 assessment. When deciding to access information from these sources, judgement is required, to determine relevancy for the specific allegation (i.e. we should only be seeking to review information which will assist in the assessment of that allegation). Note that no singular source of information exhausts what is referred to as the Historic Claims body of knowledge, and it is likely that a range of sources will need to be reviewed to ensure that an assessment considers all available relevant records and results in a detailed and coherent analysis of the particular claim.

There are three primary information sources available to Historic Claims. Refer to Appendix A for how to use available records to research various allegations.

TRIM and CYRAS

TRIM is the database used to document and manage paper files, including all physical social work records. Records can be requested for the purpose of a Step 2 analysis from TRIM. These searches are undertaken by the Historic Claims administration team.

This can include:

- Personal records (information held about the child's time in care)

- Family records, including sibling records (these provide critical information, given that at times files were created for multiple siblings and a claimant's information may be held in these)
- Adoption records
- Other young peoples' records, where specific to the claim
- Caregiver records
- Staff files
- Residential and institutions records (general information about the operation of residences, as well as admission registers, secure and daily logs and diaries - which provide information about client movements)
- Family Home files
- Section 396 providers.

How to refine a search

TRIM searches can retrieve a high volume of records, and providing specific information about what you are looking for can assist in narrowing down a search to retrieve the most relevant information for the claim. Fill out a Historic Claims file request with as much detail as possible, including accurate spelling of names and dates of birth, any aliases known of the claimant from their time in care. Providing details about the period of care and location will also assist.

CYRAS

CYRAS (which stands for Care and protection, Youth justice, Residences, Adoptions System) is a database which holds the electronic version of a person's care records. It was developed and rolled out in the 1990s. This is not something that will usually need to be searched as CYRAS records for a claimant will be available as part of the personal/family files that are made available prior to an assessment commencing. However, from time-to-time, CYRAS searches may need to be carried out for more contemporary claims where step 2s are being completed as it holds caregiver files and the care records for other family members and young people.

These searches are carried out by the Historic Claims administration team.

EDRMS (aka Objective)

EDRMS is the main information system for National Office staff to save information that records our business activities and decisions. It stands for 'Electronic Document and Records Management System' and is also known as 'Objective' (the name of the vendor). This is one of Historic Claims key information sources, for research in relation to claims (see Appendix A for further details).

Several key documents to have general familiarity of for the purpose of assessment exist in EDRMS, including:

- Social Welfare Residential Care 1950 – 1994 (an overview of residential social work policy and practice in New Zealand which includes profiles on some key residences (research paper prepared by Wendy Parker)
- "Understanding Kohitere" (a qualitative report about Kohitere)
- 20th Century Social work in Aotearoa New Zealand – an overview of legislation policy and practice

- White case guidance (primarily for claims relating to Epuni and Hokio in the 1960s and 1970s)

Historic Claims Application

The Application provides a wealth of information including past assessed allegations. Refer to the Historic Claims Application guides on Confluence for operating within this space.

Using filtering, you can research:

- Allegations and assessed allegations (including whether the criteria for assessment was met)
- Staff member and caregiver names of alleged perpetrators
- Alleged perpetrator descriptions
- Residences/institutions and homes
- Time periods of abuse and practice failures
- Location of abuse
- Descriptions of abuse

It is important that you always return to the source document where possible (e.g. a claimant's assessment document) to ensure that you have the context about previously assessed allegations or specific details captured in the Application.

Claimant records

Where a record has been created outside of a claimant's involvement as a child with Child, Youth and Family or its predecessors and is therefore not directly related to their claim (e.g. where a claimant, as an adult, has applied to be a caregiver), consent should be sought from the claimant before seeking to access this record to ascertain if it might contain information relevant to their claim. Where provided, this consent should be clearly recorded in the claimant's EDRMS record and noted in the claimant's assessment record. Where consent is not provided, the claimant's wishes should be respected even if the record might contain relevant information.

Information held by the Ministry that has been provided by the claimant for another purpose (e.g. information provided to Service Delivery for benefit purposes) is not to be accessed for the purpose of completing the assessment of a claim.

Undertaking a search where a placement cannot be confirmed in personal/family records for a claim assessment

Where a placement for a claimant cannot be confirmed from personal and family files, and based on the information gathered we believe that the reason we have been unable to confirm this placement is due to missing information/files, additional steps should be taken in an attempt to confirm this (for a claim assessment or step 2). This may involve reviewing any potentially relevant residential registers, logbooks, diaries, Family Home records, caregiver records etc. to identify if the claimant was placed as stated.

This does not need to occur where the assessor has concluded that the reason this information does not exist is due to the Ministry not being responsible for the placement.

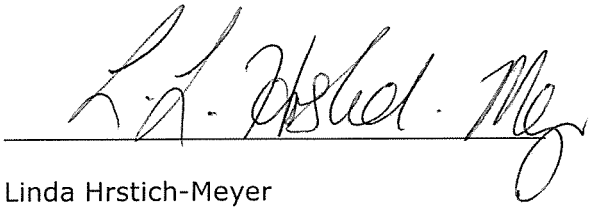
This check does not affect the threshold that the relevant allegation is assessed under, and is undertaken for fact checking purposes only. Care must be taken to ensure that

information is only gathered to complete the claim assessment (i.e. only information would be sourced to confirm the placement, and not beyond this unless the allegation was being assessed under a step 2 approach). If the information gathered for the purpose of fact checking a placement points against the allegation, this may be used in the assessment of a claim.

Team Leaders should be consulted where searches for this purpose are undertaken.

Approve practice guidance – Information sources for assessment

Approve/Decline



26.10.2021

Linda Hrstich-Meyer

Date

General Manager Historic Claims

Appendix A

Nature of allegation	Records that may be relevant	What you might expect to see in those records
Allegations against caregivers	**Caregiver/Foster parent files (TRIM and CYRAS)**	Note that these may be in the name of the caregiver couple or just one partner (historically, this was generally the female caregiver). These files are not always available and may never have been created in the first place. The further back in time you go will decrease the likelihood that a caregiver file existed. Often Social Welfare offices kept records of caregivers only on index cards rather than full files. Where a file does exist, you would expect to see an application to be a caregiver, police and referee reports and some form of file note that reflects consideration of the application and a decision. The requirements for approval changed over time, so ensure that any review of a caregiver approval considers the requirements of the day. You may also see notes about the placement of children (though note that there was no expectation that regular files notes about a child be placed on the file), and notes of any issues, complaints or commendations.
	Historic Claims Application	The Application can be filtered to research: • Allegations and assessed allegations (including whether the criteria for assessment was met) • Staff member and caregiver names of alleged perpetrators • Alleged perpetrator descriptions • Residences/institutions and homes • Time periods of abuse and practice failures • Location of abuse • Descriptions of abuse
	***"Caregivers/Foster Parents"* (EDRMS folder)**	This folder contains information about some caregivers and foster parents (arranged alphabetically) that Historic Claims has gathered information about over time. This is not an exhaustive list, and should be used in conjunction with information available in the Application and, where available, caregiver records.

	Social Work Manuals and Circular Memos	The manuals include policy on requirements for the assessment and approval of caregivers, placement of children with caregivers, management of children in caregiver care (e.g. discipline). EDRMS folder "*Social Work Manuals and Policy*" contains or includes links to handbooks and manuals that may be relevant.
	Caregiver Handbooks/Manuals	These provided guidance for caregivers. They were not consistently available over the decades.
	Files for other CYP placed with caregivers	If either the caregiver or claimant's files identify other CYP placed at the same or similar time as the claimant, then it may be appropriate to check their files (physical and/or CYRAS) to identify any issues with or allegations made about the caregiver.
Allegations against residential staff or relating to residences	**Introduction** Residences were required to maintain a number of different records. Not all have survived the test of time. For some residences there are quite complete sets of records, and for others, less so. Comprehensive file searches have been completed by Historic Claims for a number of residences and many records will be available in the relevant EDRMS folder. If in doubt, you should not hesitate to request another TRIM search (either for a specific record or more general search). You would expect to find the following types of records for most residences (note that they may go by slightly different names depending on time period).	
	Admission/discharge register	Records the details of each child admitted to and discharged from the residence.
	Daily diary/Log book	Records routine events of the day including movements of the residents (e.g. court appearances, home leave)
	Incident/Occurrence register/log book	This may be separate to or included in the daily diary or daily log, and record particular incidents (e.g. absconding)
	Secure register	Records the details of each child placed in secure care (the date and time of entry and release, the reason for the admission etc.). This may also record movements of the child, comment on the behaviour of child and of any incidents. It is possible that there may also be a separate **Secure diary** used to record day-to-day events within the secure unit.

	Punishment Register	When corporal punishment was permitted, there was a requirement to keep a record of each child who was punished.
	Administration files	There will likely be a range of files for administrative matters, including details of the physical property. These may be useful to confirm for example the physical details of secure, whether or not a particular building existed etc.
	Audit and inspection files	Residences were required to undergo inspections and audits (the requirement of which varied depending on the time period) and these files can contain valuable information about any issues the residence had to address and the extent to which these issues were or were not addressed. The audit reports for the 1990's and 2000's can be particularly valuable.
	Staff personal/HR files	For permanent staff appointed to a residence, it would be expected that a staff/HR file existed, although not all have survived. Where this type of file exists, it should provide details of the staff member, the various positions they have held and details of performance; both positive and negative. Temporary staff did not typically have an HR file.
	Staff administration files	There may also be staff files for the residence that record issues about staffing matters (e.g. requests to national office for more staff, staff shortages, rosters etc).
	Social Work Manuals	All manuals make reference in some way to residential care; its purpose and policy around specific issues such as discipline/punishment, health, education, the use of secure care etc. and should be referred to as required to determine if an alleged failure was a breach of policy.
	"*Residential Information*" and "*Staff*" (EDRMS folders)	***Residential Information*** This folder identifies residential facilities, and may include aliased assessments, profiles of the residence, research and records relevant to that particular Residence. Note that these files can include scans of some files, such as daily logs, secure logs and residential information. Though if the relevant time period for the allegation being assessed is not available, this can be sought through a TRIM search. ***Staff*** This folder includes dividers with staff names that Historic Claims has gathered information about over time. A TRIM search of a staff member should always be carried out as well.

		These folders may include aliased assessments, interviews with claimants, or other information, which can support your assessment. This folder includes staff lists, including the Master staff list. It is important that you always return to the source document where possible (e.g. staff HR files) to ensure accuracy.
	"*Social Work Manuals and Policy*" (EDRMS folder) and "*Circular Memorandum*" (EDRMS sub-folder)	Prior to the introduction of the Residential Care Regulations 1986 (see below), practice policy for the care of children in residences was contained in the various social work manuals, including the Residential Workers Manual, 1975. Circular memorandum were also regularly issued providing updates to policy.
	Legislation	Refer as required to any sections in the 1925, 1974 and 1989 Acts relevant to residences and residential care.
	Residential Care Regulations • **Children and Young Persons (Residential Care) Regulations, 1986** • **Children, Young Persons and Their Families (Residential Care) Regulations, 1996**	The regulations set out detailed requirements on the care and management of CYP in residences and are the best source document for the fundamentals of residential care.
Allegations against Family Home caregivers	**Caregiver/Foster parent files (TRIM and CYRAS)**	Caregivers appointed to Family Homes had to go through the standard approval process relevant to the time, so there should be a file in the name/s of the caregivers contracted to the Family Home at any point in time.
	Family Home files (TRIM)	There should be a file or files in the name of the Family Home. When searching for them you should use different key words as the file title may not always be the same as the name the claimant provides. The file may contain any or all of the following: • the contract appointing them caregivers of the home • details of any children of their own that they may have

		• names of children placed with them • notes of any issues, allegations or commendations • records of administrative matters • reason for the caregivers' contract ending • names of relieving caregivers and cleaners
	***"Family Homes"* (EDRMS folder)**	This folder contains information about some Family Homes (arranged alphabetically) that Historic Claims has gathered information about over time. This is not an exhaustive list, and should be used in conjunction with information available in the Application and, where available, caregiver records.
	Historic Claims Application	The Application can be filtered to research: • Allegations and assessed allegations (including whether the criteria for assessment was met) • Staff member and caregiver names of alleged perpetrators • Alleged perpetrator descriptions • Residences/institutions and homes • Time periods of abuse and practice failures • Location of abuse • Descriptions of abuse
Allegations against church providers	**Files in the name of the home**	For many years a number of the mainstream churches ran children's homes. These homes had to be inspected and approved by MSD's predecessors. You should expect to find (assuming they have survived) files in the name of the home. These files may contain any or all of the following: • inspection and approval reports • regular inspection/audit reports • possibly some details of staff (MSD does not hold individual files for any staff employed by the church home) • notes of any issues of concern • details of capitation subsidies • possibly names of CYP placed in the home
	• ***"Anglican Church Homes"*** • ***"Baptist Church Homes"*** • ***"Catholic Church Homes"*** • ***"Childrens Homes"***	These folders will contain varying amounts of information collated by the team about specific church homes including some claims connected with the homes.

	• ***"Methodist Church"*** • ***"Presbyterian Social Services Association"*** • ***"Salvation Army Homes"*** **(EDRMS folders)**	Some folders may have sub-folders for specific homes.
Allegations against NGO staff/caregivers	**Approval/Contract files (TRIM)**	NGO's approved under sections 396 and 403 of the 1989 Act will have files established in their name to record the details of their application and approval. These files may have been established by and were originally "owned" by either Child, Youth and Family or the Community Funding Agency (CFA). The files should (may) contain details of: • the nature of the programmes they run/services they deliver • their application • their approval and any conditions that may apply to that approval • copies of contracts between the NGO and MSD • any issues raised about the performance of the NGO
	District Office Files (TRIM)	Some individual CYF offices may have kept their own files for specific NGO service providers. These files may contain details of: • the relationship between that office and the NGO • specific services provided to the office • CYP and/of families referred to the NGO
	• ***"Child and Family Support Services"*** • ***"Childrens Home"*** **(EDRMS folders)**	This folder contains a number of sub-folders in the name of specific NGO service providers. There will be varying amounts of information in each depending on the extent to which they have been researched to address specific claims. The "Children's Home" folder contains some information about a small number of homes run by various organisations.
General resources	**Specialist topics in EDRMS**	These folders are specialist areas that on occasion have relevance to an individual claim. Detailed familiarity with this information may not be necessary, though it is useful to know it exists in the event the claim being worked on relates to one of these specialist areas.

	(E.g. Adoptions, Care Leavers, Maatua whangai – Policy and Practice and Medical Information)	
	Publicly available information	Searches in publicly available information sources, such as the internet, can be useful for example to see if there is any publicly available information about an alleged perpetrator.
	Police checks	If it is helpful to determine if an alleged offender has had previous convictions and there is nothing available in the public domain, then it may be possible to confirm specific details with the New Zealand Police. Any approach to the New Zealand Police must be coordinated by or completed in conjunction with advice from the Lead Claims Advisor.
	Academic research	It may be helpful to refer to academic research to inform/support a particular issue.

Responsible Adults, Inaction and Inadequate Practice

Last review date: October 2021 (new practice guidance)
Approved by: Linda Hrstich-Meyer
Owner: General Manager Historic Claims

Allegations fall into one of three categories:

- ***Abuse by responsible adult***
- ***Inaction, insufficient action or inappropriate action***
- ***Inadequate practice***

As part of the current claims model, Historic Claims has categorised the issues for which MSD is responsible for the purpose of the Historic Claims process (though not necessarily legally responsible) so they can be organised into payment categories. Examples of allegations that fall within these categories can be found in Appendix A.

The Historic Claims process is an Alternative Dispute Resolution (ADR) process and, as noted in the MSD Historic Claims Business Process and Guidance, does not involve establishing facts and liability in the same way a court does. This document should be read within that context.

Abuse by responsible adult

Responsible adults are agents of Child, Youth and Family or its predecessors[1] who have care and protection responsibilities for the child. Such agents are caregivers, staff at Family Homes or Residences, social workers or other employees of the service. Staff or caregivers employed by NGOs or Iwi Social Services contracted to provide services on behalf of the Ministry would generally also fall into this category where the Ministry would otherwise have responsibility.

While these types of roles are easily identifiable as responsible adults for the purpose of the Historic Claims process, some relationships are less clear and exceptions can exist. While not possible to outline all possible exceptions, the following factors support us to determine responsibility:

- Legal status of the child
- Funding of the placement
- The role of the alleged perpetrator
- Social Welfare's role with the child, in making a placement, and/or monitoring this placement; and
- Social Welfare's contractual relationship with the alleged perpetrator.

[1] For the purpose of this practice guidance, the various iterations of social welfare agencies will be referred to collectively as social welfare.

Example

The Ministry does not generally accept responsibility for the actions of medical practitioners or health staff, even when the claimant was under the care, custody and guardianship of Social Welfare and placed in a social welfare facility. Complaints about medical practitioners is generally the responsibility of an organisation within the Health sector (e.g. the Ministry of Health) to respond to, and we can support claimants to engage with their process. On occasion, Social Welfare employed or contracted a doctor to a residence (which is different to a doctor providing health services to children in a residence through a Ministry of Health contract or arrangement). Where clear evidence exists that a doctor was contracted by Social Welfare to a residence, allegations of abuse made against them may be taken into account.

Who are not responsible adults

Generally, all those who have not been given formal legal responsibility towards the child or young person by social welfare or recognised as having that role by the state such as those related to, or living with, responsible adults. See above for possible exceptions.

Parents are not regarded as "responsible adults" by this definition and framework (even when the child or young person was in state care, custody or guardianship).

Seeking advice on responsible adult status of an alleged perpetrator

Seek advice from Lead or Senior Claims Advisor, Team Leader and/or from MSD Legal. Before doing so, establish as far as possible the above factors outlined to support decision making in this space.

Practice failures relate to both Inaction and Inadequate practice

The following two categories (Inaction and Inadequate practice) are both practice failures. The difference being:

- inaction refers to a practice failure by a responsible adult that contributed to the alleged abuse of the child or young person
- inadequate practice refers to a practice failure by a responsible adult that affected the standard of care the child or young person experienced but did not contribute to alleged abuse.

The identified practice failures may be the same (e.g. a lack of visiting, an absence of caregiver assessment). The critical difference when determining whether a practice failure is inaction or inadequate practice is whether the practice failure contributed to abuse or neglect.

Inaction, Insufficient Action or Inappropriate Action

There are three types of 'action' above that are summarised into the one word of inaction for the purpose of our model. Inaction is simply a relationship between a failure on the part of Social Welfare (namely a responsible adult), that contributed to abuse or neglect of a child or young person.

Inaction means that Social Welfare did not respond (or respond adequately) where it was legally required to and/or policy or accepted practice directed it to (e.g. a failure to investigate or act on a reported concern). *Insufficient action* may be that action was taken but not to the extent that would reasonably be indicated or required to protect the

child (e.g. an inadequate response to an allegation of abuse). *Inappropriate action* may be a decision made by a responsible adult that then contributes to alleged abuse or fails to protect from alleged abuse (e.g. a young person is required to room with another young person who has known harmful sexual behaviour).

We do not expect claimants to have knowledge about the service they were entitled to receive or what the Ministry's responsibilities were. Our role is to understand whether the Ministry's action or inaction contributed in some way to abuse that a claimant has alleged. In this way we establish a reasonable link between the failure and the abuse the claimant has alleged.

When claimants share their account of their care experience, it is important that we take steps to understand from the claimant's perspective what was happening at the time of alleged abuse (e.g. if the claimant describes an initiation beating occurred upon being admitted to residence, it is important to try to understand staff awareness or involvement when this happened). We also consider records to determine any noted inaction that is not visible to the claimant (e.g. a failure to assess a foster parent, who is then alleged to have sexually abused the claimant).

Inadequate Practice

Inadequate practice occurs when a responsible adult fails to comply with relevant policy and/or legal obligations. We know this has an impact on the standard of care the claimant experienced and their rights while in care. For the most part, inadequate practice relates to Social Welfare employees where they are guided by legislation, policy and practice requirements. However, there may be times that it is appropriate to include caregivers (as responsible adults) where they failed to follow policy.

Examples of where inadequate practice occurs is when there is an absence of visiting, engagement, planning, support, approving and assessing from Social Welfare agents. This inadequate practice could have resulted in multiple placements, schooling instability, a sense of isolation or a lack of belonging and identity.

Approve Practice guidance – Responsible Adults, Inaction and Inadequate Practice

Approve/Decline

26.10.2021

Linda Hrstich-Meyer

Date

General Manager Historic Claims

Appendix A

Abuse by Responsible adults

- Physical assaults by staff at a residence
- Sexual assaults by Family Home caregiver
- Staff were verbally abusive
- Neglected by a foster parent
- Physical and emotional abuse by foster parent

Inaction contributing to abuse

- She was raped by her Grandfather on multiple occasions. No one believed her even when she fell pregnant and in case notes the social worker documented that he thought she was a liar [*Failure to act*]
- Physically abused and neglected by parents. Child, Youth and Family was notified several times but there was no investigation [*Failure to investigate*]
- When father was drunk he was a very violent man; everyone in the family was beaten regularly. The Ministry investigated but put it down to strong discipline. [*Failure to take sufficient action*]
- Sexually abused by the son of the foster parents. Social workers never visited her in care, and she had no one to tell she was being abused. [*Failure to visit*]

Inadequate practice

- There is little evidence of any active monitoring during this first period of her placement [*Failure to monitor*]
- He doesn't remember social workers visiting him or ever talking to them [*Failure to visit*]
- Uncle was a gang member and he shouldn't have been put in this placement without a background check [*Failure to assess safety and/or placed in an unsafe/inappropriate environment*]
- She needed glasses and the dentist, but the foster mother didn't take her. [*Failure to access health services*]
- Brother was placed with him the first two years in care, but then was moved and he doesn't know why, and he didn't see him for years later. [*Failure to support family/whanau contact, Failure to inform/involve in decision making*]

Settlement Documentation

Last Review date:	October 2021 (new practice guidance)
Approved by:	Linda Hrstich-Meyer
Owner:	General Manager Historic Claims

There are three documents that need to be drafted when preparing settlement documentation:

- Letter of Offer. This letter sets out the Ministry's response to a claimant's claim. It records the allegations that are being taken into account and those that are not, along with reasons for why not. They also include the Ministry's settlement offer and provide administrative details around settlement.

- Settlement agreement. This records the agreement reached between the claimant and the Ministry, including that the agreement is being entered into as "full and final settlement". It is legally binding on both the claimant and the Ministry.

- Apology letter. This is a personalised apology letter from the Chief Executive of the Ministry acknowledging a claimant's time in care. There is also a covering memo from the General Manager to the Chief Executive summarising the claimant's experience.

Letter of Offer

This letter is the Ministry's formal response and offer to the claimant. Although this means that care must be taken to align with language used by the Ministry in the management of claims (e.g. taking allegations into account), the letter can still be personalised for the claimant in a way that shows compassion and provides a meaningful response. For claimants who choose not to meet with the Ministry (these are often legally represented claimants), the letter of offer is generally one of the main interactions they receive from the Ministry and the only feedback they will receive from the Ministry on their claim. It is therefore important that care is taken in crafting this response.

While some sections of the letter of offer are standardised to ensure consistent messaging for claimants, the template for this letter allows scope for personalisation (e.g. in the summary of concerns section). Additional sentences can also be added if appropriate (e.g. if we have verbally offered to connect the claimant with another agency to register a separate claim, this could be reiterated in the letter).

There are a number of important things to think about when writing a letter of offer. These include:

- Consider the template to use - There are three main templates; direct, represented (but unfiled) and filed represented claimants. There is also less regularly used templates including one where a nil payment is being made and one for filed claimants where the Ministry of Education is a defendant. If writing to an estate, discuss this with the Lead or relevant Senior Claims Advisor as some changes will be needed.

- How would the claimant like to be addressed? Direct claimants may have previously indicated to Claimant Support a preference (e.g. by first name or surname).

- In the summary of concerns section, think carefully about how you can summarise the claimant's concerns in a way that is meaningful to them. For example, if the claimant has a primary concern or there is part of a claim that is particularly important for them to have addressed, make sure this is mentioned in the summary. Likewise, you may not need to include a minor allegation that did not seem important to the claimant or is more peripheral to their primary concerns. This part of the document is intended to reflect the claimant's reported experience (in a general sense). Therefore, this can include significant aspects of their reported experience which the assessment of their claim has or has not taken into account. The length of the summary section will likely differ for each claimant depending on the nature of their claim, but in most claims a paragraph would be a reasonable length.

- In most cases, 'first person' language should be used (such as "you" and "your"), including in the appendix. This is the case for both direct and legally represented claimants. The letter is written to the claimant rather than to their lawyer, where relevant.

- Think carefully about the level of detail provided in the allegations in the appendix. It is ok for the allegations to look slightly different than what has been recorded in the assessment. For example, it will not usually be necessary to include every specific detail of the alleged abuse, especially if it is sensitive in nature (e.g. sexual abuse).

- Given the historic claims process is an alternative dispute resolution process, it does not seek to establish the facts of a claim in the same way a Court does. We do not 'accept' allegations, but rather we determine whether we will take certain allegations into account for the purposes of making a settlement offer. As a result, care needs to be taken with including specific names of alleged offenders. Names will not usually need to be included in the appendix if there is another way of referring to them "e.g. *the Titahi Bay Family Home caregiver punched you...*" or "*staff at Epuni failed to intervene when you were receiving an initiation beating*". Where you are proposing to include an alleged perpetrators name, consult with your Team Leader and/or Lead or Senior Claims Advisor for advice.

- Carefully consider the reasoning to be included for why allegations have not been taken into account. Is it clear? Is the tone of the response empathetic (remember that this is a section that explains why the Ministry has not taken into account a part of their experience which may feel very personal to them)? Have you included enough detail? Have you used language that the claimant will understand?

Settlement Agreements

A settlement agreement is a legal document which is binding on both the claimant and the Ministry. It is not the Ministry's role to provide advice to the claimant on the agreement. Though Claimant Support should make direct claimants aware that they can seek legal advice on the terms of the agreement before they sign it. As noted in the letter of offer for direct claimants, the Ministry will pay up to $400 for the claimant to consult a lawyer. If the lawyer requires additional time to provide advice, they can contact the Ministry to discuss this. If a settlement agreement is being handed to a claimant at an in-person feedback, the Claimant Support Specialist should strongly encourage claimants to take away the document to read it and consider before signing. It will not generally be appropriate to allow a claimant to sign the agreement at feedback.

If Claims Assessors have any questions about the wording to be used or the template, this can be discussed with the Lead Claims Advisor or the relevant Senior Claims Advisor.

Apology Letters

For many claimants, apology letters will be extremely important to them and may be more significant than the monetary payment. Therefore, care should be taken with the letter to ensure that it is personalised, empathetic and as meaningful as possible to the claimant.

Tips to personalise an apology letter:

- Has the claimant asked for the letter to cover any particular matters? If a feedback meeting took place, check the meeting notes for any comments about this.
- Does the claimant have allegations that they were particularly concerned about that have been included for the purposes of settlement? If yes, these should be included.
- Try to use the claimant's language where possible. For example, if the claimant said in their interview or letter from their lawyer that they felt "*let down by Social Welfare*", these types of phrases can be reflected back in the letter.
- Refer to specific residences or programmes the claimant attended where they have raised concerns.

An appendix to this guidance provides some example sentences that can be incorporated or used as inspiration for a personalised apology letter.

Apology letters should not contain any language which suggests that we have accepted that the allegations have been proven. Instead, statements focussing on what the claimant has raised with the Ministry should be used. For example, "*you described abuse by staff while living at Kohitere….*"

Specific details of abuse, allegations or sensitive information are not generally included in an apology letter, unless the claimant has requested this. If there is a request for this detail, this should be noted in the apology letter covering memo. Do not use adjectives such as "serious" or "significant" to describe abuse, especially when it has a defined

meaning in the assessment process. If it is to be used, the reasoning should be included in the covering memo.

Names of alleged perpetrators of abuse are not to be included in the letter.

Appendix: Example sentences for apology letters

The following examples may assist when customising an apology letter. It is important that the letter reflects the claimant's own words/language and specific experiences. You do not have to use these examples exactly. The letter should not repeat the same words or sentiments in different places and should be tailored to the nature of the claim.

Introductory sentences:

- Thank you for having the courage to share your deeply personal experiences with us.
- Thank you for having the strength to contact us and tell us about your time in care.
- Thank you for sharing your experiences with us.

Sentence openers for framing allegations:

- You described experiencing...
- You told us...
- You raised concerns about the social work practice provided to you .....
- You describe how you were...
- You described several incidents of...
- You shared your memories of...

Some examples of how to frame allegations

- You described experiencing abuse by several staff members at Kohitere and being punished inappropriately by staff members.
- You told us that you remember abuse and being mistreated by your caregivers in a variety of placements. You also described being hurt by other residents while at Epuni Boys' Home.
- You described abuse while living with a foster family and how this left you feeling distressed and alone.
- You identified the challenges you faced as a young person and raised concerns about the social work provided to you during this time.
- You have also raised concerns about the social work provided to you and the decisions made in relation to your care.
- You told us that you continued to be hurt and felt unsafe when you were returned to your mother or father's care, and that you believe social workers did not act to keep you safe.

Sentences responding to allegations:

- I am very sorry that these are the memories you carry from your childhood.
- I acknowledge that these experiences were incredibly difficult to share, and I understand that they continue to impact your adult life.
- No person should be led to believe that abuse is normal.
- I am very sorry for the distress that you experienced as a child.
- I can only imagine how difficult these years were for you.

- This must have been a difficult time for you.
- This must have been a very distressing time for you, and I am truly sorry for that.
- I know this must have been a very difficult thing to do, and I appreciate the strength it took to share some very distressing memories.
- I would like to acknowledge the incredible strength and bravery you have demonstrated.
- I have a lot of admiration for you and all that you have overcome.

Including positive comments

When including positive comments, keep the focus on the claimant's own achievements in childhood or adulthood; avoid examples of a positive time in care as this can be seen as minimising the claimant's negative experiences of their time in care. The apology letter should unreservedly apologise and should not seek to remind the claimant about good things that also happened, or to balance a negative experience with a positive one.

Examples to avoid

Avoid phrasing which could imply that we disbelieve the claimant (e.g. "I am told that you believe" or "I appreciate that you believe you could have been").

Be careful not to invalidate the claimant's experience or suggest that how they feel about their experiences is incorrect or should be different. For example, "no person should remember their childhood this way" could imply that the onus is on them. Instead you could say "No person should carry these memories of their childhood..."

When referencing how a claimant feels about their experiences, draw on their own words. We should not be telling any claimant how we assume they feel, but rather reflecting that we have heard what they have told us.

Approve practice guidance – Settlement documentation

Approve/~~Decline~~

L. L. Hrstich-Meyer

Linda Hrstich-Meyer
General Manager Historic Claims

26.10.2021

Date

Timelines

Last review date: October 2021 (new practice guidance)

Approved by: Linda Hrstich-Meyer
Owner: General Manager Historic Claims

Timelines provide an account of the role the State played in a claimant's life, generally based on the claimant's personal and family files as well relevant institutional records. Just as every claimant's experience is unique, so is their interest in understanding decisions which were made about their time in care or events which occurred during this time. Timelines should be factual, provide a meaningful account of the claimant's involvement with the State for the purposes of assessing their claim, and built upon by Claimant Support to support Historic Claims to deliver a seamless end-to-end claims process.

This begins with understanding what is important and meaningful to the claimant.

A claimant's interview or correspondence with the Ministry may raise questions about their time in care or decisions which were made. Factors such as the age of the claimant, the passage of time since they were in care, the trauma they may have experienced, and moving through multiple placements can contribute to confusion about their care journey. This can be helped by constructing a factual account of a claimant's care journey to share with them.

Timelines are constructed and built upon for two purposes; to support the assessment of a claim and to support a meaningful discussion with a claimant about their care journey. Having a visual aid at the point of providing feedback to a claimant may support them to reflect on their care experience and claim before the conclusion of the process.

Consider the purposes a timeline can serve

- It provides a visual picture of the key events during the course of the claimant's involvement with Child, Youth and Family or its predecessor agencies; the events that brought the claimant to attention, the events that occurred during state involvement and those that led to involvement ceasing.
- It provides the context within which the claimants allegations sit.
- It shows a claimant's movements in and out of care, in and out of placements, and identifies the duration of those placements.
- It marks those periods of time that we did and did not have legal responsibility for the claimant.
- Significantly, for the claimant it can provide an overview of their involvement with Child, Youth and Family or its predecessor agencies, and either confirm their recollections of events, or assist them in understanding more about their care journey.

What to include in a timeline for the purpose of assessment

A timeline with relevant factual information is created during the assessment process and documented in the Assessment template.

The timeline constructed in the assessment template is focussed on the information relevant to the assessment of the claim (*i.e. if the claimant was in care for a number of years and traversed multiple placements, but their claim is related to one incident, the assessment timeline can focus specifically on that period in their care journey).*

Timelines need to be factual, based on records, and easy to understand. Terminology used should be easy to understand, and where legal statuses are used, these should be referenced by their full order (rather than purely the section of the relevant Act) (*e.g. Guardianship order to the Director-General, s.31(3) Children and Young Persons Act 1974*). Placement names should be written in full (*e.g. Hamilton Boys Home*). Non-Government Organisation or section 396 provider placement details should be noted as such. Caregiver details should clearly define their role (*e.g. DSW caregiver, family/whānau caregiver*).

A timeline constructed during assessment may include:

- The key events that first brought the claimant to attention. This is particularly relevant where there are allegations relating to pre-care involvement.
- The legal basis on which the claimant was in care or under our control. Equally important is to note the periods of time when the claimant was not in the care of or involved with Child, Youth and Family or its predecessor agencies.
- The correct legislative reference under which orders were made
- The dates that placements start and finish (*e.g. Ministry placements, informal whanau care arrangements*).
- The dates that orders and agreements start and finish.
- Key events, relevant for the purpose of the assessment (*e.g. noting secure admission dates if the claim relates to treatment in secure, noting when a claimant was removed from a caregiver's home due to an assault).*

Additional information to consider including in a timeline for the purpose of providing feedback to a claimant

Where relevant, and where it will form part of the basis of providing feedback to claimants, the timeline can be built upon by Claimant Support, which may include additional information that is relevant to the claimant's experience in care that was not relevant for the purpose of assessing their claim. This may include areas of interest directly raised by the claimant, or key issues that Claimant Support consider will support a meaningful feedback.

This may include:

- Key events that occurred for the claimant (*e.g. the death of a family member, the point a separation from a sibling occurred, moving to another part of the country*).

- Key dates and decisions relating to a claimant's time in care, to be able to respond to questions that claimants may have about their involvement with the State.

The nature of the timeline, where relevant, can be developed to meet the individual claimant's needs, taking into account what will be meaningful to them, any learning disabilities which may require a different presentation of the information, and support a discussion about their experience in care.

The presentation of the timeline (e.g. a table, visual timeline) for Claimant Support's purpose of providing feedback to a claimant will depend on the individual claimant's needs and nature of the claim. Where legally represented claimants request a feedback meeting in person, or where they specifically ask for a timeline, the same approach is given to considering what will be meaningful in a timeline.

Approve practice guidance – Timelines

Approve/~~Decline~~

26.10.2021

Linda Hrstich-Meyer

Date

General Manager Historic Claims