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BRIGIT MIRFIN-VEITCH - AFFIRMED

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EXAMINED BY MRS THOMAS

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5 **CHAIR:** Once you are settled, I would like under the
6 terms of the inquiries Act to ask you to confirm
7 the following, Dr - (witness affirmed).

8 **MS THOMAS:**

9 Q. Do you have a brief of evidence before you in the folder?

09.35 10 A. Yes, I do.

11 Q. And can you confirm that is your brief of evidence that
12 you have signed and dated?

13 A. Yes.

14 Q. You confirm that is correct?

15 A. I do.

16 Q. Thank you. Do you also have on the table before you the
17 document "Institutions are places of Abuse"?

18 A. Yes, I do.

19 Q. And that is a report that you have co-authored with
09.36 20 Dr Jenny Conder?

21 A. Yes.

22 Q. I would ask you now to produce that document as Exhibit 6
23 in this hearing.

24 A. Yes.

25 Q. Just before we begin your evidence today, I understand
26 you would like to make an acknowledgment?

27 A. Yes, I would. Tena koutou katoa. Before I begin, I
28 would like to acknowledge the disabled children and
29 adults who have formed and shaped my own understandings
09.36 30 of abuse. It is their stories that underpin the brief I
31 am speaking to today. Many of these individuals are no
32 longer with us and were therefore unable to support the
33 call for an Inquiry into an abuse in care, sadly these
34 men and women will also never know that thousands of

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1 New Zealanders joined together to demand an Inquiry and
2 an apology on their behalf and that demand was
3 ultimately successful. It is these people I acknowledge
4 today, along with those who are yet to tell their
5 stories.

6 Q. Thank you. Can I just ask - just a reminder, we will be
7 speaking slowly because everything we are saying is being
8 typed up, so we will just pause if necessary.

9 Can you please tell us briefly who you are and your
09.37 10 area of expertise?

11 A. Sure. As you know, my name is Brigit Mirfin-Veitch I am
12 a Director of the Donald Beasley Institute which is a
13 position that I've held since 2007 but I've been a member
14 of the DB I staff since 1994.

15 The Donald Beasley Institute is an independent
16 charitable trust that conducts research and education in
17 the area of disability and we have a specific focus on
18 learning disability.

19 I am also a Senior Research Fellow with the Centre
09.38 20 For Postgraduate Nursing Studies University of Otago and
21 Adjunct Associate Professor of Deakin University. I am a
22 sociologist, I have a strong interest in understanding
23 the social lives with learning disability and I am
24 committed to initiating and achieving social change
25 through research.

26 My research has explored deinstitutionalisation from
27 the perspective of family members, of people with
28 learning disability who were moving from Templeton
29 Centre.

09.38 30 **CHAIR:** It may be helpful if you keep in your sight the
31 stenographer who is functioning at high speed but
32 will be assisted if you keep an eye on the pace.

33 A. Sure thing. I was just noting that I've done research
34 around deinstitutionalisation that focused on the

1 Templeton Centre, a large institution for children and
 2 adults with learning disability located near
 3 Christchurch.

4 I was also part of a team of researchers from the
 5 Donald Beasley Institute who explored the
 6 deinstitutionalisation or closure of Kimberley Centre,
 7 one of New Zealand's last or New Zealand's last large
 8 institution to close.

9 I was also engaged with institutionalisation and
 09.39 10 deinstitutionalisation more recently as a co-author of
 11 *"Institutions are places of abuse": The experience of*
 12 *disabled children and adults in State care*, which was
 13 published in 2017 and which was an exhibit that I showed
 14 earlier.

15 I will note that the title of that piece of work, we
 16 acknowledge Robert Martin who will be speaking next week
 17 as the person that provided the inspiration for that
 18 title.

19 In addition, throughout my 25 years as a disability
 09.40 20 researcher with DB I, I have conducted research in the
 21 area of parenting by people with learning disability,
 22 health and wellbeing, the justice system and more
 23 recently around sexuality and relationships, and all of
 24 this research has included a significant number of people
 25 with learning disabilities who have reported that they
 26 experienced abuse in care during research institutes,
 27 despite the fact that the research was not specifically
 28 about abuse.

29 Q. Thank you. You've been asked to give evidence at this
 09.40 30 hearing today about the nature and extent of abuse and
 31 neglect that has occurred to people with learning
 32 disabilities in State care between the 1950s and 1990s?

33 A. Mm-Mmm.

34 Q. And you've drawn on the report "Institutions are places

1 of abuse", as part of your brief?

2 A. Yes.

3 Q. Just before we get into the detail of your evidence,
4 there's various terminology that you've used in your
5 brief, can you please take us through that, just to
6 explain the terms?

7 A. Sure. I've been asked to give evidence about the nature
8 and extent of abuse and I'm going to talk about the
9 impacts of such abuse on individuals. But one of the
09.41 10 things that I did note in my brief, that I am not a
11 clinician, so as a first parameter around the evidence
12 that I'm giving, is that I'm a researcher. I hear a lot
13 about people's, I research people's experiences and what
14 I'm going to talk about today is are those experiences
15 and how people have felt, what they've told me about
16 them, though I do note I am not a clinician, so I'm not
17 making a clinical judgement about the impacts that people
18 have experienced when they're talking about abuse in
19 care.

09.42 20 I think the other part of your question is related
21 to how we did the research?

22 Q. Yes but also perhaps just in terms of the - if you turn
23 to paragraph 10 of your brief.

24 A. Sure.

25 Q. You refer to the terminology to be used when referring to
26 someone with a learn disability, if you could take us
27 through that?

28 A. Sure. I will take a step back and note that the research
29 that we're talking about today was undertaken in 2007
09.42 30 (sic) 2017 during the campaign for a Commission of
31 Inquiry into Abuse in Care. The research was contracted
32 by the Human Rights Commission and with detailed research
33 so that we could capture the voices and experiences of
34 disabled people as part of this conversation that was
going on.

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1 I note that I use the term learning disability
2 throughout the brief. People first New Zealand, which is
3 a Disabled Persons Organisation promote the use of the
4 term learning disability instead of intellectual
5 disability. They feel the term is more respectful,
6 reflective of the difficulties they experience and easier
7 to say. So, therefore, learning disability is the term
8 that I'm using today but in doing so, I acknowledge that
9 intellectual disability, mentally retarded or mentally
09.43 10 subnormal were commonly used terms during the period
11 1950-1992.

12 Q. You've said your research responded to a concern that
13 disabled people, including people with a learning
14 disability, comprise a significant part of the silent
15 majority who have not told their stories of abuse?

16 A. Mm-Mmm.

17 Q. Can you tell us what are the reasons why people with
18 learning disabilities have not told their stories of
19 abuse?

09.44 20 A. I think there are a number of reasons that create the
21 silence. First and quite simply, people with learning
22 disability have often not been asked. Second, they have
23 told their stories and no-one has listened or responded.
24 And thirdly, it's possible that abuse is so expected and
25 pervasive that people have not recognised that they have
26 been abused.

27 Other reasons relate to the fact that sexual abuse
28 can be a taboo topic and when coupled with disability, it
29 becomes even more taboo.

09.45 30 Another reason that people may not have told their
31 stories of abuse, is that we, researchers and others, are
32 often afraid to open up a space for them to do so.
33 People with learning disability can be seen as too
34 vulnerable to talk about abuse, they can be seen as

1 lacking the capacity to do so. But in our experiences,
 2 researchers in this area simply by creating an ethically
 3 and emotionally safe space to talk, such as we do in
 4 research, people have felt able to talk about the abuse
 5 they've experienced. And we have noted many times that
 6 when research is not focused on abuse, that that's simply
 7 been provided with a safe and non-judgmental space for
 8 discussion where people are presumed to have capacity,
 9 appears to empower people to disclose abuse in all its
 09.45 10 forms.

11 So, fundamentally, we need to make sure that people
 12 with learning disability know that it's okay to talk
 13 about abuse if we want to ensure that abuse is
 14 challenged. The historical evidence we drew on showed
 15 that people were scared to talk about the abuse, abuse
 16 that they'd experienced when it happened to them, because
 17 of further ramifications. And we will talk about that
 18 later.

19 Because they knew they wouldn't be believed or
 09.46 20 because there was no mechanism for them to take their
 21 complaint.

22 So, it could be argued that people with learning
 23 disability might continue to experience these attitudinal
 24 and systemic barriers and we need to ensure they don't.

25 Q. In terms of your research particular to the document, the
 26 Institutions are places of abuse, what were the aims and
 27 purpose of that research?

28 A. One of the concerns was that as the conversation and the
 29 discussion grew around the call for an Inquiry into abuse
 09.47 30 in care, that disabled people weren't part of the
 31 conversation. And so, the sort of - the motivation, I
 32 guess, for the research that we did, was to show that
 33 disabled people did have a place in this conversation and
 34 had experienced abuse in care and actually were high

1 users of care, State care at the time, when they set out
2 to do this research.

3 So, our aims were to determine what is known or what
4 was known about the abuse of disabled people,
5 particularly those with a learning disability, and
6 particularly to think about systemic abuse and whether
7 there was evidence that that was at play.

8 To identify gaps in the available evidence about
9 abuse of people, disabled people in care.

09.48 10 And at that time we were thinking about what sort of
11 research pathway had the potential to address gaps in
12 knowledge around this area, which was another aim of the
13 work.

14 Q. Were there any limitations or constraints to your
15 research?

16 A. Yes, considerable ones. We had a very, very short
17 timeframe and obviously limited resources. So, we had to
18 think, you know, yeah, think carefully about how we
19 approached this piece of work and how we could bring the
09.48 20 voices of disabled people to the fore within the
21 timeframe and resources that we had.

22 Q. Were you able to - did you have resources to look into
23 psychosocial disability?

24 A. That is one of the areas that we didn't delve into too
25 deeply. They are a group of people, disabled people,
26 that could have been included in this research but we did
27 have quite a strong focus on learning disability. And in
28 noting that we didn't draw on a great deal of evidence
29 relating to people with psychosocial disability, people
09.49 30 who have experienced mental distress, that we were
31 definitely not saying that they were not part of the
32 experience of abuse that other disabled people who we
33 were able to capture in the research were also part of.

34 Q. Just for clarity, can you tell us what is a psychosocial

1 disability?

2 A. A psychosocial disability is the terminology used in the
3 UN Convention on the Rights of Persons with Disabilities
4 to refer to people who experience mental distress or
5 psychological conditions. These differ from learning
6 disabilities, in that they're generally episodic, can
7 sometimes be alleviated by medication and don't
8 necessarily involve cognitive impairment but it's really
9 important to note that people with learning disability
09.50 10 can also experience psychosocial disability as well.

11 Q. What was your research methodology when you undertook
12 this research?

13 A. So, I think this question speaks back to your question
14 about the constraints and how we thought about
15 approaching this work. So, the approach that we used was
16 to conduct an integrated literature review which is a
17 very well recognised way of doing research where you draw
18 on the literature to see, you know, what is available
19 around the topic that you're interested in.

09.51 20 We did it this way because there wasn't time or
21 resource to do primary research where we went and worked
22 directly with the people who had experienced abuse. So,
23 essentially, what we did was looked to the literature,
24 looked to resources and publically available documents of
25 all types that contained evidence of abuse experienced by
26 people with disabilities and primarily learning
27 disabilities. That was already available, that contained
28 stories and evidence of abuse that we had possibly
29 overlooked.

09.52 30 Q. The stories you drew on already existed in the public
31 domain and you brought them to light?

32 A. Yes.

33 Q. As part of your research design, were you required to
34 define what constituted abuse?

1 A. Yes, we did.

2 Q. How did you do that?

3 A. Yeah, we did that in two ways. The first was by
 4 utilising pre-existing definitions or types, categories
 5 of abuse as codes to begin with. And we did the - the
 6 second way we did it was by being responsive to the
 7 content and recurring issues raised in the data as other
 8 less well recognised forms of abuse came forward.

9 One of the additional categories that we developed
 09.52 10 or included in the research, was, for example, one of
 11 restraint, a category of restraint, and we did this
 12 because it featured really heavily in the stories told by
 13 individuals.

14 Arguably though, we could have categorised restraint
 15 as falling into psychological abuse or physical abuse
 16 categories. So, it's noted in our work, abuse categories
 17 were not neatly delineated. People often experienced
 18 abuse across a spectrum of categories and some categories
 19 of abuse share common features. So, any emotional,
 09.53 20 psychological element to all physical elements across
 21 categories of neglect and physical and sexual abuse.

22 Q. I think you've defined at least 7 different types of
 23 abuse in your brief which we'll come to shortly.

24 A. Yep.

25 Q. Just turning now to paragraph 27 of your brief, your
 26 research has referred to personal accounts of 13 men and
 27 5 women?

28 A. Mm-Mmm.

29 Q. Would you have preferred to have a bigger sample than
 09.54 30 that?

31 A. Yes but I think those 13 men and 5 women told us a lot
 32 about abuse in care but from a technical point of view,
 33 in qualitative research there's no specified or required
 34 number for sample size. The intent of qualitative

1 research is to acquire a depth of understanding of the
 2 lived experience of an individual or a group of
 3 individuals. So, the quality of qualitative research is
 4 not determined by how many people said something but by
 5 the authenticity of the account and its transferability.

6 That said, of course we would have liked further
 7 accounts but the size of the body of data is not
 8 surprising, given the nature of the individuals. And
 9 it's also noted and we'll probably talk about it later,
 09.55 10 that in all of the individual stories were with a trusted
 11 person or researcher. So, there is no question that many
 12 people with learning disability could have told their
 13 story but would struggle to do so without this
 14 assistance.

15 Q. We've heard evidence earlier in the week from Judge
 16 Henwood in relation to the Confidential Listening
 17 service, and she commented about despite reaching out to
 18 groups of people with learning disabilities, that service
 19 really struggled to have people come forward. Are you
 09.55 20 able to comment on that at all and offer any solutions?

21 A. Yes. I think I spoke to it slightly earlier, that
 22 because people with learning disability often don't
 23 receive the same level of value as others, that in
 24 situations like this their stories aren't sought out as
 25 much or they're not seen as part of this particular
 26 context or situation.

27 But, as I said earlier, our experience has been in
 28 providing a really safe place for people to tell and to
 29 talk, that they often do and often when we don't expect
 09.56 30 them to.

31 So, my advice would be to think about ways to
 32 provide supported approaches to people telling their
 33 story but thinking very carefully around who might be
 34 involved in that with people, a trusted person is

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1 particularly important, not simply expecting people to
2 turn up to something where they don't necessarily
3 understand the process or have a relationship with the
4 people that are delivering the intended support or
5 opportunity to tell their story.

6 Q. The accounts that you drew on for your research, can you
7 tell us the types of disabilities that the people in that
8 research group experienced?

9 A. Most people were identified as having a learning
09.57 10 disability. Others had a combination of disabilities,
11 including a learning disability, being blind, having
12 physical disability, a learning disability as well. One
13 person was deaf and another described as having a
14 traumatic brain injury from a childhood illness. Others
15 had cerebral palsy and one other person had been
16 misdiagnosed, came up in the literature that we drew on
17 that had been misdiagnosed with learning disability as a
18 young child which led to him being institutionalised for
19 a very long time in a psychopaedic hospital.

09.58 20 Q. Just on that point of this person who was misdiagnosed,
21 can you tell us what happened there or how that would
22 have happened?

23 A. Because we were drawing on, you know, secondary
24 literature resources that had already been put together,
25 we weren't working with people directly. Our
26 understanding is the person had come from a situation of
27 family hardship and ended up being placed in an
28 institution and then not getting out of that placement
29 for a very long time.

09.58 30 Q. What types of State care were these people that part of
31 your research, what types of State care were they placed
32 in?

33 A. The critical thing to note is that in the accounts and
34 the evidence that we drew on, people had been in a range

1 of State care or care placements across a really long
 2 period of time. So, people had spent time in
 3 psychopaedic hospitals or institutions, psychiatric
 4 hospitals or institutions, they'd been in residential
 5 homes, educational placements and faith-based
 6 institutions for some and foster care, only a small
 7 number had experienced foster care within the time period
 8 we were looking at.

9 However, that is not surprising, given that most
 10 people with learning disability or other disabilities
 11 would likely have been placed in the larger scale
 12 institutions rather than foster care at that time.

13 Q. You've referred to the word psychopaedic hospitals, can
 14 you clarify for us what is a psychopaedic hospital?

15 A. Psychopaedic is a uniquely New Zealand term that was
 16 developed by a linguistic in the 1960s and applied to
 17 hospitals or large institutions for people with learning
 18 or intellectual disability only. Psychopaedic nursing
 19 became a nursing specialty for staff who worked in those
 20 hospitals and institutions and the term translates to
 21 mind of a child. That's the kind of translation of that
 22 term.

23 Q. So, these institutions were purpose built in New Zealand
 24 at that time for these people with learning disabilities?

25 A. There were four psychopaedic institutions in New Zealand,
 26 two in the North Island and two in the South Island.
 27 They existed for longer than the terminology of
 28 psychopaedic but which came in later. So, psychopaedic
 29 or institutions that were only for people with learning
 30 disability were the Templeton Centre, Kimberley Centre,
 31 Braemar and Mangere.

32 Q. What was the ethnicity of the people in your research
 33 group?

34 A. In terms of ethnicity, because again we were drawing on

1 secondary sources, so we had to go with what we could see
 2 in the literature, in that data. It was often not
 3 clearly stated but we knew that three people whose
 4 stories we drew on identified as Maori and another
 5 identified as Pasifika Cook Islands decent, and the rest
 6 we assumed to be Pakeha, New Zealand.

7 Q. What was age or roughly the ages of people in your group
 8 when they were placed in care?

9 A. Again, because we were drawing on secondary sources, we
 10.02 10 could only go with what was in people's stories or, you
 11 know, what was included in those but without exception
 12 they'd all entered State care in childhood and had often
 13 remained in State care or in care into adulthood and many
 14 had remained in some form of care for their entire lives.

15 Q. I'd just like to move now to paragraph 35 in your brief
 16 where you mention case studies. Your research included
 17 case studies about abuse that happened to an individual
 18 person but also about being abused by being exposed to
 19 maltreatment of others and being powerless to stop that?

10.03 20 A. Yes.

21 Q. Are you able to give us an example of that?

22 A. Yes. What we were able to do, was from some of the
 23 sources that we were able to utilise, there was a lot of
 24 information about people's experiences in care. And from
 25 those we could kind of pull together a case study of the
 26 person's whole life in those kinds of environments and
 27 then with other sources we drew on we saw snippets of
 28 experience that we could use to gain an understanding of
 29 the types of abuse that people with learning disabilities
 10.03 30 and other disabilities were experiencing.

31 In terms of the case studies, for some people, and I
 32 won't go into a lot of detail because I think Robert
 33 Martin will speak to this next week, but certainly
 34 Robert's experience that he has bravely shared with the

1 world showed the really complex interplay of experiencing
 2 abuse himself but also being deeply conscious of the
 3 abuse that others were experiencing around him and
 4 feeling concerned about that too. So, having - and he
 5 wasn't the only person that expressed how difficult it
 6 was to be experiencing this yourself but also seeing
 7 others and being powerless to do anything about that.

8 Q. If we move now to the different kinds of abuse that you
 9 focused on in your research. Which one of those featured
 10.04 10 more frequently than any other?

11 A. Within our research, so as I said before, we did more
 12 detailed case studies which could show people what life
 13 was like on a daily basis but then we also did an
 14 analysis to go what were we seeing frequently for a lot
 15 of people? And within our research, we found that
 16 neglect featured more frequently across the different
 17 life stories in comparison to any other form of abuse.
 18 And arguably, being in State care could be read as
 19 synonymous with neglect due to the fact that even if
 10.05 20 people aren't being overtly abused, they were generally
 21 exposed to an extremely impoverished relational
 22 environment, that is most of the stories we engaged with
 23 people talked about feeling as though no-one cared for
 24 them or knowing that no-one cared for them.

25 Q. I think you've mentioned a range of different areas of
 26 neglect, could you just give us some examples of those?

27 A. So, I think in general we found that people frequently
 28 and consistently described living situations or being in
 29 living situations where they didn't feel loved, that they
 10.06 30 had no special person in their lives who was there to
 31 love and support and nurture them.

32 Other experiences of neglect could be seen in the
 33 lack of emotional support and connection that people
 34 received, particularly at times of distress.

1 One person whose life story that we drew on, a
 2 person who I know very well personally or a knew very
 3 well personally, she is no longer with us, said "I was
 4 scared a lot in institutions, I would scream a lot, I
 5 would get in the corner and put my hands over my face and
 6 no-one ever came to comfort me." So, here's a person, a
 7 young person at the time, describing living in a series
 8 of institutions all over the South Island, absolutely
 9 recognising that her behaviour was an expression of
 10.07 10 distress and that no-one ever came to help her feel
 11 better or to check why she was feeling that way.

12 Rather, some of the things which leads from that
 13 quote, was that people did recognise that rather than
 14 staff being attuned and responsive to their emotional
 15 needs and the way that they were trying to manage them,
 16 that people were actually punished for challenging or
 17 non-compliant behaviour.

18 Other things that we saw were in terms of neglect
 19 were survivors' self-esteem being affected, with a number
 10.08 20 of people linking their experiences in care with lifelong
 21 feelings of being unwanted, feeling an acute absence of
 22 affection or emotional support and some survivors
 23 attributed this to a difficulty they had as adults to
 24 show affection and trust other people, things that we've
 25 probably heard in other survivor accounts over the last
 26 week.

27 Q. What did you note in terms of lack of stimulation?

28 A. What was interesting, is that obviously a lot of the
 29 people whose accounts and stories we drew on were able to
 10.09 30 articulate their experiences. They could communicate and
 31 share their story with another person and have it told.
 32 What's noteworthy, is they talked about, you know, the
 33 fact that they didn't experience a lot of stimulation and
 34 there wasn't much to do but they were also concerned

1 about others who may have had a greater degree of
 2 impairment who really, really were left to their own
 3 devices and, you know, when they were totally reliant on
 4 other people for care or being engaged with some activity
 5 were left for long periods of time with no-one attending
 6 to their needs.

7 Q. As a result of that, were basic needs not met?

8 A. Yes. One survivor recalled the smell of people who
 9 needed assistance to go to the bathroom and were not
 10.10 10 provided and said there were people who couldn't move and
 11 they just, would just stay where they had been left in
 12 the morning after breakfast, most of these people were
 13 non-verbal and were trapped until someone got around to
 14 attending to them.

15 Q. Can I ask you now to talk to us about the emotional and
 16 psychological abuse that you researched?

17 A. Yes, and I think as I noted earlier, there's a lot of
 18 cross-over between these sort of arbitrary categories of
 19 abuse and certainly, this category could also be placed
 10.11 20 or has significant cross-over with neglect as well. But
 21 emotional and psychological abuse was also really
 22 apparent. The life stories and other sources of data we
 23 analysed conveyed a sense of deep fear, of hostility and
 24 distress, of experiencing hostility towards themselves
 25 and of feeling distressed which I think most people would
 26 agree are all strong indicators of emotional and
 27 psychological abuse.

28 As we noted earlier, this kind of abuse could be
 29 seen in both personal maltreatment that people
 10.11 30 experienced and also due to their repeated and ongoing
 31 exposure to the maltreatment of others.

32 Some of the people with learning disability and
 33 other disabilities who told their stories in the body of
 34 data we were able to work with, interpreted some of their

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1 own behaviour as a tangible expression of distress and
2 they saw self injurious behaviours as other people were
3 engaging in, as their way of communicating distress. And
4 they also recognised that there was a failure to respond
5 to those self injurious behaviours and talked strongly
6 about that.

7 Q. Your report mentions survivors living in constant fear,
8 what impact did that have on their lives long lasting?

9 A. Again, that pattern of people reporting feeling fearful,
10.13 10 feeling that no-one was there for them, was a repeated
11 frame coming through with them talking about their later
12 lives. You know, particularly noting a difficulty in
13 trusting people and making relationships. But in the
14 moment, for some people that fear of being physically
15 hurt while they were in the environments that they were
16 in meant that they put their own protective mechanisms in
17 place and for one person she reported that she simply
18 chose to stop talking. Talking got her into trouble and
19 the response to people's perceptions about her and her
10.14 20 behaviour meant that it was safer for her to not talk.

21 Q. You've said at paragraph 58 that survivors left State
22 care with an entrenched understanding that people in
23 positions of power could hurt them if it they failed to
24 comply with expectations?

25 A. Yeah.

26 Q. Can you explain that?

27 A. Sure. The point that we were making was that the
28 individuals who told their stories of abuse at the time
29 all talked about the fact that nothing could be done
10.14 30 about it or that no-one helped them address it. Asking
31 for help or assistance led to no action or negative
32 action. That is, that there was some kind of negative
33 ramification for them. So, it's not surprising that that
34 was the learnings that people carried with them for their
life.

1 Q. I'd like to ask you now some questions about power and
2 abuse. At para 61, you've quoted there the statement
3 that, "Abuse is the overt representation of an imbalance
4 of power relations"?

5 A. Mm-Mmm.

6 Q. Can you explain that to us?

7 A. Sure. I think I'd like to draw on the work of Professor
8 Dick Sobsey at this point and perhaps just make a
9 personal comment before I explain his particular model of
10.15 10 abuse and people with disabilities. It was interesting
11 when we'd been exploring this topic and preparing for
12 today's hearing to draw on this particular book by
13 Professor Dick Sobsey who is a Canadian researcher. He
14 is an extremely well respected researcher and this would
15 be seen as the most important text on abuse and people
16 with disabilities. Some interesting historical context,
17 is that Dick, Professor Sobsey wrote a lot of this
18 manuscript in 1991 when he was a visiting Professor at
19 the Donald Beasley Institute. And the other interesting
10.16 20 thing to note, is that the foreward to this book, which
21 is an international text which is circulated the globe
22 now for 25 years, it was published in 1994, it has the
23 foreward in this book has the story of a New Zealand
24 survivor of institutional abuse, Mavis May, and Professor
25 Sobsey met or came across May during his time here in New
26 Zealand. So, I think in terms of thinking how we can
27 miss people with disabilities in this story, we have done
28 so for 25 years, we have had evidence sitting in front of
29 this book about a personal account of abuse provided by a
10.17 30 New Zealand woman, as I say, has circulated the globe
31 because many, many people draw on this book to understand
32 abuse in the lives of people with disabilities. But I
33 digress a little bit there.

34 So, what - I am not sure, do we have the slide?

1 Q. If we could ask for the slide to be put up there now,
2 thank you.

3 A. So, what we thought would be a useful way to think about
4 the abuse that disabled people may have experienced or
5 have experienced in care, is by drawing on Professor
6 Sobsey's model as a way of helping people to understand
7 the sort of power dynamic that's at play when people
8 experience abuse.

9 So, Professor Sobsey draws on a very famous
10.18 10 ecological model or way of understanding the world that
11 was developed by another researcher. He uses it to
12 explain how abuse was able to occur. Very briefly, what
13 he does is highlights the abusive context reflect
14 inequities in power at a relational and environmental and
15 cultural level. This can really usefully explain why
16 abuse occurred and why it remained unchecked in
17 institutional and other care environments.

18 In short, he says that abuse occurred in the context
19 of power inequities. So, what you can see in the model
10.19 20 is that in the middle there is a circle which highlights
21 relationship and it shows the dynamic between offender
22 and victim or perpetrator and survivor, whatever language
23 you want to use. And notes that what starts to happen is
24 that there's a developing power and equality or equity
25 and there is a weakened bond between the two.

26 He then looks at the environment that this happens
27 in and notes that there aren't counter-controls. There's
28 no way or process for stopping inequities happening, in
29 fact they're magnified.

10.19 30 Around the outside he uses the term "culture" to say
31 there's something at play that provides the support and
32 rationale for the power and inequities and the abuse to
33 occur.

34 The reason that I was thinking about this and

1 thought it would be useful to present, is when I was
 2 thinking about, after sort of listening and watching
 3 Keith Wiffin earlier in the week who talked about the
 4 kingpin system, that model is a pretty good way to
 5 explain how such a system could happen. And I would also
 6 like to note that while they didn't use the same terms
 7 and words that Keith Wiffin used earlier in the week,
 8 that people's stories that we drew on were quite clearly
 9 describing the same system, that there were more powerful
 10.20 10 people than them and that you had to be careful of these
 11 more powerful people within the situations that you were
 12 in.

13 So, people with learning disability and other
 14 disabilities were not unaware of that system in
 15 operation, even if they did not use that terminology.

16 Q. Can I ask you now to talk to us about control and
 17 restraint?

18 A. Mm.

19 Q. As a form of abuse.

10.21 20 A. Yes. As I said earlier, that was something or an area or
 21 a theme that came through very clearly and strongly and
 22 was really expressed in a distress that people had about
 23 being confined to the institution itself, to their
 24 bedrooms or specially constructed seclusion rooms.

25 This practice could also be considered to fall into
 26 the abuse category of psychological and physical abuse as
 27 well, just noting that cross-over. We view these
 28 practices of control and restraint as comprising such a
 29 significant component of the data that we analysed it as
 10.22 30 a separate and distinct form of abuse. So, being locked
 31 up was a prominent experience with many of the survivors
 32 describing that in detail and being very distressed by
 33 it. Being locked up was sometimes due to perceived
 34 challenging behaviours but sometimes it was just the

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1 practice of that institution.

2 In addition to noting the physical confinement to
3 particular rooms and spaces, people also reflected on the
4 highly regulated and regimented spaces and activities
5 within the institution, including being told but not
6 limited to when to shower, when to shave, when to eat,
7 when to dress, when not to dress. Others described the
8 process of establishing and forcing routine and physical
9 confinement as excessively harsh, with some survivors
10.23 10 sharing evidence of control and psychological restraint
11 created by staff restricting the space people were
12 allowed to be in, and by restricting their ability to
13 interact with friends.

14 I would like to draw on a quote which evidences
15 this. "They used to put you in pyjamas, that was a
16 horrible thing, they used to have a square table by the
17 kitchen which was the really bad table. If you run away
18 they put you in pyjamas, you had to stay in pyjamas all
19 day while others had their clothes on. You had to sit in
10.23 20 one corner by yourself and you don't have your friends
21 around you".

22 Overall, this particular theme conveyed a strong
23 sense of being trapped in State care literally and
24 figuratively, and confined and restricted on a daily
25 basis in a manner that people perceived as hurtful, as
26 excessive and as humiliating, as the previous quote
27 evidences.

28 Q. Can you also talk to us about physical abuse and what the
29 research found in relation to that?

10.24 30 A. What was interesting and possibly worrying to find, was
31 that across the body of data, the evidence, the
32 testimonies from people that had made their way into the
33 public domain, physical abuse wasn't talked about as much
34 as some of the other categories. So, I think it's really

1 important to note, for example, that a lot of what people
 2 did talk about in these accounts was the neglect and the
 3 psychological and emotional abuse that they experienced.
 4 The control and restraint was a big area. And physical
 5 abuse was kind of of like a given and people didn't talk
 6 about it as frequently. I'll come to sexual abuse in a
 7 moment.

8 But what they did talk about was really quite
 9 extreme physical abuse. So, people talked about being
 10.25 10 beaten by peers frequently and severely. They also
 11 clearly identified physical assaults carried out by
 12 staff. One survivor describing dragged down a corridor
 13 by either feet or hair as punishment. Sometimes small
 14 misdemeanours were met with excessive force, such as
 15 being kicked or accidentally breaking something.

16 And I have, I will illustrate with a quote, "When I
 17 was 13 one of the big boys picked me up by the back of
 18 the collar, lifted me off my feet, punched me in the
 19 nose, on the side of the nose and made it bent. I went
 10.26 20 up to the nurse and told her that my nose was broken, she
 21 said she wouldn't do nothing about it".

22 So, significant experiences of physical abuse.

23 Q. Can you talk to us also about sexual abuse and what was
 24 discussed there?

25 A. So, in keeping with the Crimes Act and with more
 26 contemporary definitions, we define sexual abuse as any
 27 form of sexual contact that was not consensual or any
 28 form of sexual contact that happened within two children.
 29 And on both of these elements of the definition were
 10.27 30 identified within the personal accounts we explored. We
 31 found that both children and adults were sexually
 32 assaulted. We found that the assaults occurred in large
 33 institutions, residential schools and within the family
 34 homes of their foster carers.

1 I have a quote here before moving on with some more
 2 information. Someone who lived at Templeton Centre for
 3 many years described sexual abuse, said "sexually abused,
 4 sodomised, you know, I suppose you could say that it
 5 continued on, not just only me but I think a lot of other
 6 people too."

7 So, while sexual abuse was frequently divulged or
 8 talked about in the narratives, often people touched on
 9 it briefly, we know it's fairly graphic. This is likely
 10.28 10 to be because many of the resources that we pulled the
 11 information from were not really designed by way of
 12 method or in thinking about the ethics of them to respond
 13 to disclosures of abuse. So, often we were finding this
 14 information in resources that had been written about
 15 deinstitutionalisation as things move into the community,
 16 about their life story etc. But that said, it was clear
 17 from the evidence we drew on that sexual violence was a
 18 seemingly inescapable and unchallenged reality for a
 19 significant number of both boys and girls and men and
 10.29 20 women in State care. Some of the narratives included
 21 graphic experience of the person's abuse, including when
 22 it happened, where it happened and who the perpetrator
 23 was.

24 Q. Did the people that were part of your research talk about
 25 what happened if they did tell someone about the abuse?

26 A. There didn't seem to be a lot of evidence in people's
 27 stories that people had ever had any redress. For
 28 example, one survivor was sexually assaulted at knife
 29 point by an older peer when she was 11, despite being
 10.29 30 able to point him out, there was no sense in her story
 31 that the perpetrator was punished, kept away from her or
 32 she received any psychological support for that sexual
 33 violence.

34 Similarly, and also shockingly, another male

1 survivor raped by older peers appeared to go
 2 unchallenged. And others also described similar
 3 situations, again seemingly unchallenged. I am noting
 4 here we are using secondary sources, we weren't talking
 5 with people directly, but essentially there was little
 6 evidence to suggest there was ever any follow-up and
 7 evidence to suggest that the reverse, in fact.

8 **COMMISSIONER SHAW:** Could I ask a follow-up question on
 9 that? I appreciate you're working from secondary
 10.30 10 sources. Was there any evidence to acknowledge
 11 that these people were telling authorities, were
 12 able to tell you? Because the answer could be,
 13 well, nobody did anything because they didn't know?

14 A. I think that might have been the case for some people but
 15 for other people it seemed to be clear that they knew
 16 that they had taken complaints to people and hadn't had a
 17 response or had had a negative response. So, I think,
 18 again, I'm qualifying my response but we saw evidence of
 19 both situations there.

10.31 20 **COMMISSIONER SHAW:** Thank you very much.

21 **MS THOMAS:**

22 Q. Just on that point, turning in your brief to
 23 paragraph 81, is that an example where someone -

24 A. Yes.

25 Q. - that you could tell us a bit more about?

26 A. Sure. One of the - yeah, so can I go back a couple of
 27 points to give some context? So, I noted in my brief
 28 that survivors consistently echoed the same sentiment in
 29 response to permeated trauma they experienced, commenting
 10.32 30 they would keep quiet and hoped it wouldn't happen again.
 31 Similarly to reports of physical abuse, there was this
 32 deep-seated understanding that complaints would go
 33 nowhere and could even make your situation worse.

34 This view is echoed in a judgement that we located

1 as part of the research for this piece of work that
 2 related to someone who had been in a couple of different
 3 institutions. And the judgement evidenced that this
 4 complainant felt devalued by staff, thus leading to the
 5 dismissal of complaints within State care and some
 6 subsequent revictimisation. So to this end the judgement
 7 reported the position and said, "Despite the complaint,
 8 the plaintiff says that sexual acts continued to be
 9 forced on him by that and another nurse for several
 10.33 10 months. The plaintiff says that he did not complain to
 11 other staff because he thought it would be dismissed and
 12 he was scared of what could happen.... He says he did not
 13 report the events of witnessing sexual assaults on others
 14 because he was scared of the consequences of the charge
 15 nurse not believing him".

16 Q. Can I ask you to touch on the next heading of abuse that
 17 you've covered there, spiritual abuse?

18 A. Again, spiritual abuse was something that we didn't draw
 19 a lot of evidence about but we thought it was important
 10.33 20 to include because it was significant for a number of
 21 people. So, while less recognised, spiritual violence
 22 featured heavily in the accounts of a person with a
 23 learning disability who was Maori, whose experiences in
 24 institutions conveyed a sense of loss with regard to
 25 being disconnected from his culture as a child. State
 26 care facilities in which this survivor was placed were
 27 both Pakeha centric in culture and lacked cultural
 28 competence for Maori and Iwitanga. He was denied access
 29 to his culture as a Maori man and more specifically to
 10.34 30 his iwi which he noted in his story. Other Pakeha
 31 survivors noted their heritage was ignored. I am sure
 32 Robert will speak to this next week and people recounting
 33 a sort of broader disconnection from New Zealand and the
 34 world and historical events.

1 And then at a more individual level, people talked
 2 about being able to - being unable to pursue their own
 3 interests and their passions, despite expressing them,
 4 not being given the opportunity to pursue them. So,
 5 living a life very devoid of that individuality that
 6 makes us all the people that we are.

7 Q. The last type of abuse that you've covered in your
 8 research, financial abuse?

9 A. We noted this. Only a few survivors referred to their
 10.35 10 financial material deprivation. However, we did note
 11 that people experienced such a significant lack of
 12 education or support to develop the skills required for
 13 meaningful employment if they did escape this environment
 14 as perhaps evidence of long-term financial abuse. But
 15 probably more prominently in their stories, financial
 16 abuse could be seen as illustrated through the experience
 17 of, you know, yep, compromised access to education and
 18 the erosion of people's ability to be employed. But it
 19 could also be seen in people being denied opportunities
 10.36 20 to have possessions, to enjoy the money they potentially
 21 could have earned if their forced labour in institutions
 22 and other state sanctioned care environments had been
 23 recognised.

24 So, a number of the accounts talked about they made
 25 you a slave when I was 6 years old I had to help, I never
 26 went to school, they wanted me to work because I was good
 27 at it, you didn't get any money, that's for sure, you
 28 didn't get any money. Restrictive environments of care
 29 also denied opportunities to get work, as I've just
 10.37 30 mentioned, and have any level of financial autonomy.
 31 Someone said "I'm disappointed that I've never had a
 32 job, I never got the chance, money is not everything in
 33 life but I would have liked to have been able to buy
 34 clothes."

 So, briefly touched on in these comments a little

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1 considered aspect of life in care, one that I hadn't
2 thought about until I was reading people's stories, was
3 that survivors were forced to undertake manual labour,
4 both in institutions and foster homes, and this
5 surprising finding featured quite heavily. One person
6 described immediate and long-term injuries she suffered
7 as a result of heavy lifting she was forced to do and
8 others described their time as unpaid labourer for a
9 foster family.

10.38 10 In that situation, the person, the family she was in
11 was also a staff member of the institution she had been
12 living in which suggests an abuse of power of a different
13 kind.

14 Q. I would like to ask you briefly about other evidence that
15 you gathered as part of your research that came from
16 third parties. We may not have the opportunity to go
17 through it into too much detail but can you tell us where
18 you sourced some of this information?

19 A. Yes. So, the evidence that we drew on from third parties
10.38 20 was because we knew from some of the research that we'd
21 done in our own institution and other work of colleagues
22 in the disability research area, that we would - it would
23 be useful to find information or data evidence that
24 supported the stories that survivors had told. So, we
25 drew on some of those accounts.

26 And so, some of them included eye witness accounts
27 from relatives that were reported in particular stories,
28 literature, resources and other eye witness accounts from
29 researcher observation and from staff reports in some of
10.39 30 the institutions.

31 So, it's not about proving or disproving the
32 survivors' stories. We believed in those but we thought
33 it was useful to provide some more evidence if we could
34 find it.

1 Most notably, the process of deinstitutionalisation
 2 has provided an opportunity for both staff and families
 3 to talk about neglect and abuse that they witnessed in
 4 various institutions. Within the New Zealand research
 5 was explored the process of institutional closure, for
 6 example, staff members have reported that abuse was an
 7 issue at Kimberley Centre, that they witnessed abuse of
 8 practice or actions themselves. For example, some
 9 research that focused on deinstitutionalisation of
 10.40 10 Kimberley, staff members said, "I've been here for over
 11 10 years all up and these people were brought up in fear
 12 here and I've seen this, when you look at the things that
 13 went on in this place it was horrific, they were cruel,
 14 very cruel people, we had men out in the courtyard here,
 15 do you know how they got showered, with fire losses. You
 16 rush up to one of these people very quickly, they will,
 17 that's when they have hidings at a very young age, the
 18 Kimberley Cringe, that's what they call it".

19 The staff quoted there were largely employed at
 10.41 20 Kimberley Centre prior to its closure, so outside of the
 21 timeframe for this Inquiry. The quotes have been
 22 included to illustrate two important points. That abuse
 23 was occurring at the Institute beyond the focus of this
 24 research and the physical fear exhibited by the people
 25 that lived there and observed by staff and families
 26 actually labelled as the Kimberley Cringe was understood
 27 to be the result of a long-term pattern of abuse within
 28 the institution. It is acknowledged that both staff and
 29 residents may have been involved in abuse of practice or
 10.41 30 actions that led to the development of the Kimberley
 31 Cringe or people's physical withdrawal away from people
 32 that came close to them.

33 Q. I'd like to move on now to the topic, this is from
 34 paragraph 107 onwards of your brief. The question, was

1 what you've described institutional abuse?

2 A. Sure. One of the things that we considered in our
 3 research was whether the abuse that we saw when we pulled
 4 across a number of survivor stories, whether it showed or
 5 we could call it institutional abuse. And again, drawing
 6 on Professor Dick Sobsey's work, Professor Sobsey defined
 7 institutional abuse as neglectful, psychological, sexual
 8 abuse that takes place in managed institutional care of
 9 Human beings. He identified the key features as extreme
 10.43 10 power relations between residents and staff, collective
 11 nature of abuse, that abuse is covered up or knowledge of
 12 it is not shared outside of the institution and that
 13 clearly defined patterns of environmental influence are
 14 at play.

15 I'd just like to note, and possibly if I've got
 16 time, to read out. Just to extend on the points that
 17 I've just made -

18 Q. Just while you're reading a quote, can you speak slightly
 19 more slowly.

10.43 20 A. Just to extend on that point and to pick up on a question
 21 I think from the Commissioners yesterday, that he goes on
 22 to say, "Institutional care is not necessarily restricted
 23 to large custodial institutions. It includes an array of
 24 living arrangements and related programs paid for with
 25 government or other public funds that would be normally
 26 provided through less formal family and community
 27 resources. Thus, institutional abuse can take place in
 28 group homes, foster care, hospitals, residential
 29 schools, prisons and a variety of other environments and
 10.44 30 anyone can become the victim of institutional abuse,
 31 including people with disabilities".

32 Q. I'd now like you to talk to us about systemic abuse. Can
 33 you tell us about the definition of systemic abuse?

34 A. Yeah. So, in our study of survivor accounts provided by

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1 people with disabilities, and particularly people with
2 learning disability, we drew on the testimony
3 characterised by participants who were describing
4 long-term, immediate and long-term impacts as a result of
5 their abuse. And given the evidence, we really wanted to
6 consider whether their abuse could be defined as
7 systemic. We drew on the work of Sally Robinson who is
8 an Australian researcher who defines systemic abuse as
9 having causal roots that are located in organisational
10.45 10 systems or policy, despite sometimes being perpetrated by
11 a person.

12 So, in this definition, abuse can't be categorised
13 as systemic due to prevalence alone, instead, abuse must
14 be attributable or able to be attributable to system
15 factors or failures that have worked actively or
16 passively to enable or to facilitate abuse under the
17 particular system. That is in more lay person's terms
18 systemic abuse takes us beyond the notion of bad things
19 being done by bad people independent of the system to a
10.46 20 recognition that the system has operated in ways that has
21 both provided the opportunity for abuse to occur or for
22 it to continue unchallenged. And I think that's what
23 we've heard in people's stories.

24 Q. If you turn to paragraph 119 with the bullet points
25 listed in your brief there, can you just take us through
26 those?

27 A. Yeah. So, what we did against that definition of
28 systemic abuse, is create a series of points that we
29 could or key themes core findings that we could see in
10.47 30 the data that we had gathered in the survivor stories.
31 So, we noted that the personal accounts detailed neglect
32 in the form of people not having their basic needs met,
33 possibly due to under staffing or inadequate training
34 which constitutes systemic abuse. We saw

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1 institution-wide failure to attend to the emotional and
2 psychological development of children, potentially
3 through under staffing, inadequate training and abusive
4 or allowing an abusive culture to continue unchecked.

5 We saw the use of control and restraint practices,
6 whether environmental, physical or chemical, for reasons
7 of punishment rather than for therapeutic reasons which
8 constitutes systemic abuse.

9 We saw repeated exposure to physical violence
10.47 10 resulting in injuries being left untreated and no
11 meaningful attempt being made to stop the assaults which
12 constitutes systemic abuse.

13 And people being repeatedly sexually abused or
14 exposed to sexual very violence and the absence of any
15 ability to achieve meaningful redress in the form of a
16 person being held to account or counselling for
17 psychological trauma and a care system that allowed staff
18 and foster carers to abuse the children and adults in
19 their care.

10.48 20 This is all suggestive of systemic abuse.

21 Q. This systemic abuse existed that you've described, do you
22 have any comment or any thoughts on what can be done to
23 avoid this in the future?

24 A. So, what we saw, yep, we were able to draw on secondary
25 accounts that had been sitting unexplored really. So,
26 when we go back to the beginning of this session, when
27 you asked a question about why are disabled people
28 invisible, the stories were there and the stories are
29 there. We hadn't

10.49 30 looked hard enough and I think some of that speaks to the
31 value that we place on disabled people and where we see
32 them fitting in this issue.

33 But the evidence on record about the experiences of
34 abuse has largely been collected within the context of
research with an alternative focus, both in terms of the

1 nature of the data that's collected and the way it's been
 2 able to be analysed. So, we need to do further
 3 exploration to really be able to learn from our mistakes
 4 from the past but my thoughts are that in doing this, we
 5 need to examine the context in which abuse occurred and
 6 the policies and processes and procedures that were there
 7 or were not there to assess the likelihood of similar
 8 abuses permeating future systems, that speaks to the
 9 question I was asked before, did people complain, did
 10.50 10 they not complain, we need to know more about what people
 11 understood, did they understand there was a process for
 12 complaining or was there not?

13 It's also important to look closely at
 14 organisational culture at a broader level, again to
 15 generate important learnings to ensure we don't let down
 16 another generation of vulnerable children and adults.

17 Yeah, I think people who experience the trauma
 18 deserve the opportunity to learn how this abuse was able
 19 to happen, so really getting to the heart of why is an
 10.51 20 important step towards that.

21 Q. Coming near the end of your brief, one of the headings
 22 is, "Gaps in the evidence".

23 A. Mm-Mmm.

24 Q. I'd just like to ask you briefly about the comments that
 25 you've made at paragraph 132 where you've described that
 26 people telling their stories were clear about what
 27 happened but they were not able to unpack the
 28 circumstances that led to such practice or actions.

29 A. Mm.

10.51 30 Q. Can you comment on that for us?

31 A. Yeah. I think we saw a range of - there were a range of
 32 stories told and for some people they were able to give
 33 extensive detail and, you know, to have a real
 34 understanding of the power dynamics that were at play,

1 while others were simply reporting these terrible things
2 that happened to them which they knew were wrong and
3 should not have occurred but didn't have that context
4 around them.

5 So, I'll step back to your previous question. We
6 haven't got a full understanding of how these things were
7 able to occur in this system of care, so it's not
8 surprising that individuals with learning disability who
9 had often not even experienced any kind of life in the
10.52 10 community, had lived whole lives in those institutions,
11 weren't able to provide complex details or really
12 comprehensive understandings of why and how things had
13 happened, and even when they'd happened, because if
14 you've lived a whole period of life with no typical
15 signposts of times in your life, then you're not going to
16 be able to give a lot of detail about this happened when
17 I was this age, around this time etc., yeah, you don't
18 have those things, life experiences to hand that detail
19 on, contextual details on.

10.53 20 Q. Just in terms of the reference to the Askew review in
21 1980s where you stated it was unethical to explain away
22 the high incidents of abuse in State care as being
23 reflective of "the time". Can you comment on that for
24 us?

25 A. Yes. The Askew review supported the individual stories
26 that we explored. So, the review was a Ministry of
27 Health review of psychiatric and psychopaedic hospitals.
28 And Askew described the conditions despite institutional
29 reform that occurred through the '70s and '80s and went
10.54 30 on to say that some staff in institutions reported to the
31 review team that time outboxes and cupboards in some
32 wards for the intellectually handicapped were used more
33 for punishment than any therapeutic effect which was
34 deemed to be more appropriate for practice for modifying

1 behaviour. Further, they found deficiencies in dignity
 2 and in basic elements of appropriate care. For example,
 3 that some units in psychopaedic hospitals had toilets of
 4 a bench type in nature and communal showers. The report
 5 went on and said other things about what they saw there
 6 and concluded that staff shortages and low moral
 7 seriously affect patient care and the availability of
 8 alternative methods of treatment and led to a lack of
 9 awareness and general acceptance. So, it could be argued
 10.55 10 that this review conducted in the 1980s has long provided
 11 evidence that neglect and abuse in care did indeed occur.

12 **CHAIR:** Ms Thomas, I will leave it to you to suggest an
 13 appropriate time at which we might take the morning
 14 adjournment.

15 **MS THOMAS:** I only have two more questions.

16 **CHAIR:** All right.

17 **MS THOMAS:** Perhaps we finish those and then take the
 18 break.

19 Q. Just turning to the end of your brief there where at
 10.56 20 paragraph 140, statement that abuse and neglect are not
 21 in the past. Can you perhaps expand on that for us?

22 A. Yes. I think Hilary Stace is going to do that in the
 23 next session but I would just note that more recent
 24 research, as it has identified abuse and neglect are not
 25 in the past, that various approaches have been used to
 26 audit and otherwise assess quality of care and that it's
 27 clear that gaps remain that make it possible for neglect
 28 and abuse to go undetected. But I will leave it to
 29 Hilary to cover off on that.

10.57 30 Q. Finally, your final paragraph of your brief, do you have
 31 any final conclusions you would like to make to the
 32 Commission today?

33 A. Just further to the notion of the intention of the
 34 Inquiry to look to the future, I think it is important to

1 conclude by mentioning the ongoing story of abuse in care
 2 that can be seen in some of our current research. We had
 3 done qualitative research with individuals in the justice
 4 system in recent years and found that over half of our 40
 5 participants have been in and out of placement in
 6 childhood, these are all people with learning disability.
 7 Some of these people reported that they'd experienced
 8 abuse in these placements. Abuse in care has been seen
 9 again in a soon to be released piece of research which
 10.58 10 includes the story of a young person with a learning
 11 disability who, in very recent years, has experienced
 12 multiple foster placements, including an unacceptably
 13 high number of placements and some abuse in some of those
 14 settings.

15 So, unfortunately, this suggests very strongly that
 16 we are a long way from being able to confidently assert
 17 never again and it reminds us why this Royal Commission
 18 of Inquiry is so critical to disabled people who have
 19 experienced abuse in care, whether it be past, present or
 10.58 20 in the future. Thank you.

21 **MS THOMAS:** Thank you.

22 **CHAIR:** Thank you, Dr, thank you, Ms Thomas. I think
 23 we'll take the morning adjournment, following which
 24 I shall ask counsel whether they have any matters
 25 to raise by way of cross-examination and then I'll
 26 provide an opportunity for Commissioners to ask
 27 questions if they wish. Madam Registrar, could you
 28 adjourn the sitting of the Royal Commission.

11.05 30 **Hearing adjourned from 11.00 a.m. until 11.20 a.m.**

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1 **CHAIR:** We were at the point where you had concluded,
2 Ms Thomas. I now want to ask if any other counsel
3 wishes to exercise the right to cross-examine the
4 witness? There is none.

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BRIGIT MIRFIN-VEITCH

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QUESTIONED BY COMMISSIONERS

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COMMISSIONER GIBSON: Kia ora, Dr Mirfin-Veitch. Even having heard it before, I still can't help feeling deeply moved and saddened every time I hear something. Our Terms of Reference include looking to make future recommendations, so my questions cover all of that.

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Outside of that institutional context, what protections, looking at the 1989 Act, were available to disabled children? Were they the same as for other disabled children? What legal safeguards were there?

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A. I'm probably not the best person to comment on this and Hilary will speak to some of this later, I think. The area that I can talk to in terms of the safeguards around disabled children, relate to section 141 and 142 of the Children, Young Persons and Their Families Act, just noting that the Donald Beasley Institute has done a very small piece of research in that area on the basis that those two particular causes could be seen as treating disabled or did treat disabled children differently who were - so, children who were unable to be cared for at home had a different route into care and treated differently while they're in care. And what we have done, is talk to some people who have been subject to section 141 who have left their family home, gone into care and disability services and then talked about how that felt for them. So, that's a more recent experience of care that we've been able to capture in research.

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COMMISSIONER GIBSON: You talk about people with

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learning disabilities in the justice system. If I

1 was to extend that, not just to that group of
 2 people but with neurodisabilities, dyslexia, ADHD,
 3 head injury, autism spectrum, I know there's a
 4 growing global picture of these people in the
 5 justice institutions, what is your knowledge and
 6 experience of these people through youth justice
 7 and the journey into youth justice?

8 A. So, in New Zealand, we have quite a strong recognition
 9 that a significant proportion of young people in youth
 11.23 10 justice are people who would fall under that broad
 11 umbrella term of neurodisability. It's an area of
 12 research that I'm involved in in a range of ways. I
 13 think we have been drawing on international research to
 14 give us a sense of the kind of scale or the numbers of
 15 young people who may fall under that particular umbrella
 16 term that are in youth justice. We are just embarking on
 17 some research to try and get a New Zealand prevalence
 18 bigger around that but essentially I think we can be
 19 fairly confident, based on the knowledge of legal
 11.24 20 professionals, including very, very experienced Judges
 21 who are reflecting their experience and their belief that
 22 this is a big proportion of the people who we are seeing
 23 enter into youth justice. I think once we have done the
 24 research, I think it will confirm that a good number of
 25 those individuals have probably come through a pathway of
 26 care.

27 **COMMISSIONER GIBSON:** A final question, we've heard from
 28 previous witnesses about the context of adoption
 29 and the need for families to stay together. In the
 11.25 30 context of disabled parents, what do we know what
 31 happens, what support and safeguards are there for
 32 disabled parent and child?

33 A. Very few. Again, another area of research that I've
 34 worked around in the Institute, is work around in sort of

1 decade periods from the late 1990s, and we are just about
 2 to embark on another piece of research to explore the
 3 experiences of parents who have a learning disability.
 4 What we have continued to see for the last 20 years but
 5 earlier, are that parents with a learning disability
 6 frequently have their children removed at birth or soon
 7 after. They sometimes have their children removed before
 8 they have proven that they weren't good parents. They
 9 are assumed to lack capacity and, yeah, continue to
 10 experience child removal at a very significant rate. We
 11 tend not to see family reunification within families that
 12 include a parent with a disability, a learning disability
 13 at least, and we also tend to see access being eroded, so
 14 that the sort of attachment and the family relationship
 15 within those families isn't able to be maintained because
 16 they don't receive enough access and support around the
 17 access to keep that relationship going. This is an area
 18 that I feel that I can speak reasonably confidently
 19 about, hence my strong answers to this question.

11.26 20 **COMMISSIONER GIBSON:** Thank you.

21 **COMMISSIONER ALOFIVAE:** Good morning, Dr Mirfin-Veitch.
 22 Thank you very much for the way your evidence was
 23 presented and in particular the reference to your
 24 research. I suppose as a non-academic or
 25 non-research background but really appreciating the
 26 complexity. One of the questions I often ask is,
 27 at what point do we say we've got enough evidence
 28 there to actually put forward some concrete
 29 recommendations in this particular space,
 11.27 30 appreciating the limitations that you've spoken to?

31 A. Yeah. I think or my perspective is we've got a lot of
 32 evidence that we've ignored or overlooked and as a
 33 deinstitutionalisation researcher, I put myself in the
 34 category of people who have sometimes overlooked these

1 experiences. One of the things that I didn't talk about
 2 but that I noted in my brief, was that often we've heard
 3 the experiences, a lot of the data that we collected was
 4 around research that had occurred around
 5 deinstitutionalisation or life histories or oral
 6 histories that people had undertaken when they'd been
 7 moving out or soon after they'd moved out of an
 8 institution. So, while we, the collective community,
 9 disability community, were congratulating ourselves about
 10 a job well done, we were often ignoring these stories and
 11 these voices that were coming through as we were asking
 12 people to tell us about what's good about living in the
 13 community outside of these institutional systems and
 14 structures.

15 So, I think we have evidence that we can certainly
 16 assure ourselves that abuse did occur for people with
 17 learning disability and other disabilities. What I think
 18 needs to occur, is primary research with people. Our
 19 work has drawn on published accounts. I will note that
 20 some of those published accounts have originated from my
 21 organisation, the Donald Beasley Institute, so I actually
 22 did some of the research, I did know some of those
 23 people. So, there was a mix of me having done primary
 24 research that I then drew on for the work that I've
 25 presented here.

26 What we need to do is to do more of that kind of
 27 work with people and it needs to be carefully done, it
 28 needs to be slowly done, it needs to be ethically done.
 29 It's not something that you rush into without a lot of
 30 thought.

31 I will say really strongly, however, that when the
 32 context is right, people will tell those stories and
 33 people do tell those stories. So, as I said earlier,
 34 even when we're not researching abuse, we are constantly

1 hearing about it.

2 **COMMISSIONER ALOFIVAE:** Thank you. And just a final
3 question around the collation of perhaps your
4 ethnicity rating. Do you have a sense around the
5 different ethnic groups?

6 A. Yes. So, in terms of the work that I presented today,
7 are you asking me a question in relation to? We noted
8 and talked about ethnicity where we could but, again, it
9 speaks to your previous question, carefully planned work
10 allows us to explore all elements, all the
11 intersectionalities of people lives, whereas where we're
12 working with secondary data we're just taking what we can
13 from it.

14 **COMMISSIONER ALOFIVAE:** Thank you very much.

15 **CHAIR:** Dr Mirfin-Veitch, other people giving evidence
16 to the Royal Commission have referred, not all of
17 them but many, to companion pieces of work
18 occurring in Australia, Canada, United States for
19 example. Is that aspect of companion work also to
20 be thought of in regard to people with learning
21 disability?

22 A. I think by companion work, you're meaning a parallel
23 process where a slightly different process is put around
24 particular groups?

25 **CHAIR:** Yes.

26 A. That would be a really appropriate pathway. Again, what
27 we need to be careful not to do, is to treat disabled
28 people differently or think that they've had a vastly
29 different experience because I think, in listening to
30 some of the evidence this week, that I can see such
31 strong parallels. But what is important, is to think
32 about how we do work with people with learning disability
33 and to make the process accessible and sometimes that
34 might take a companion process to achieve that in the

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1 best possible way.

2 **CHAIR:** Thank you.

3 **COMMISSIONER SHAW:** I have no questions but thank you
4 for your evidence.

5 **COMMISSIONER ERUETI:** Dr Mirfin-Veitch, thank you for
6 your evidence. It is a concern, isn't it, there's
7 so little research that's been carried out into
8 abuse and neglect in these institutions and very
9 primary research so far. And it seems also that
11.32 10 there's still research that needs to be done in the
11 post institutionalisation phase about abuse and
12 neglect. I am assuming a case we heard in evidence
13 relating to mental health institutions, despite the
14 bricks and water, the large institutions that abuse
15 and neglect continues and you referred to cases in
16 the context of foster care. My question is about,
17 it seems that there's even less research that's
18 been carried out in relation to Maori and Pasifika
19 and other minorities; is that the case?

11.33 20 A. That is the case.

21 **COMMISSIONER ERUETI:** Yes, yes. I wonder, in your
22 evidence you talked about the abuse and neglect
23 experienced in institutions but is there further
24 work that needs to be carried out too on oversight
25 and standards and recruitment and training,
26 systemic factors that led to abuse and neglect
27 occurring in the institutions?

28 A. Absolutely. In one of the elements of our work that we
29 have skipped over today, was to sort of identify the
11.34 30 areas of research, the gaps that we thought were there,
31 and I'm probably unable to find that particular section
32 very quickly and probably didn't focus it completely,
33 this brief, on that. But essentially, some of the things
34 that we identified were the need to really explore this

1 notion of systemic abuse more fully. I think we've got a
 2 reasonably good, some good frameworks to work from, but
 3 to be exploring it in the context of this Inquiry, we
 4 noted that we only had a small number of participants who
 5 told stories, their stories of being in foster care, and
 6 that's largely to do with the age and the time but we
 7 know that, from more recent research, that that's a real
 8 area that we need to do some - there's gaps in the
 9 research around. Obviously, working from the perspective
 10 of Maori and Pasifika. The other area that we identified
 11 was a lot of people talked about leaving their families
 12 to go into these systems of State care and for a number
 13 of people that's because they were in difficult family
 14 situations. So, I think there's some gaps there, in
 15 terms of really exploring how we're supporting families
 16 right now and what we are - yep, how we're supporting and
 17 certainly that was, you know, a conduit to some of the
 18 placements for people that we talked with.

19 **COMMISSIONER ERUETI:** In the context of institutions but
 11.36 20 also in the post institutional phase, including
 21 foster care?

22 A. Absolutely, yes.

23 **COMMISSIONER ERUETI:** My last question relates to Maori
 24 again. You referred to the impact on individual
 25 patients and cultural disconnect and I wonder also
 26 whether there's also the bigger, broader question
 27 about whanau, hapu and iwi, Maori involvement in
 28 the setting of policy, laws and practices, the
 29 institutions themselves, so historical as well as
 11.36 30 contemporary angle and the need for work in that
 31 area too?

32 A. Yes, certainly need for work and no-one would argue that
 33 there are gaps and deficit in that area, in terms of
 34 disability, policy services supports etc. but also the

1 wider system, you will have more experience and knowledge
2 around.

3 **COMMISSIONER ERUETI:** To your mind, that work still
4 needs to be developed?

5 A. Yes.

6 **COMMISSIONER ERUETI:** Still a lot of work to do?

7 A. Yes, definitely.

8 **COMMISSIONER ERUETI:** Thank you, Dr.

9 **CHAIR:** Thank you, Dr Mirfin-Veitch, your evidence is
10 now concluded and the Royal Commission is grateful
11 for it, thank you.

12 A. Thank you.

13 **MS JANES:** May it please the Commissioner, we call Dr
14 Hilary Stace.

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