ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
LAKE ALICE CHILD AND ADOLESCENT UNIT INQUIRY HEARING

Under	The Inquiries Act 2013
In the matter of	The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions
Royal Commission:	Judge Coral Shaw (Chair) Ali'imuamua Sandra Alofivae Mr Paul Gibson
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton, Mr Andrew Molloy, Ms Ruth Thomas, Ms Finlayson-Davis, for the Royal Commission Ms Karen Feint QC, Ms Julia White and Ms Jane Maltby for the Crown Mrs Frances Joychild QC, Ms Alana Thomas and Tracey Hu for the Survivors Ms Moira Green for the Citizens Commission on Human Rights Ms Susan Hughes QC for Mr Malcolm Burgess and Mr Lawrence Reid Mr Michael Heron QC for Dr Janice Wilson Ms Frances Everard for the New Zealand Human Rights Commission Mr Hayden Rattray for Mr Selwyn Leeks Mr Eric Forster for Victor Soeterik Mr Lester Cordwell for Mr Brian Stabb and Ms Gloria Barr Mr Scott Brickell for Denis Hesseltine Ms Anita Miller for the Medical Council
Venue:	Level 2 Abuse in Care Royal Commission of Inquiry 414 Khyber Pass Road AUCKLAND
Date:	21 June 2021

TRANSCRIPT OF PROCEEDINGS

INDEX

BRIAN KENNETH STABB
Questioning by Ms Finlayson-Davis 418
Questioning by Commissioners 447

GRANT ASHLEY CAMERON
Questioning by Mr Molloy 451
Questioning by Ms Feint 486
Questioning by Ms Joychild 494
Questioning by Commissioners 502

GLORIA BARR
Questioning by Ms R Thomas 504
Questioning by Commissioners 516

Hearing opens with waiata and karakia tīmatanga by Ngāti Whātua Ōrākei

[10.07 am]

CHAIR: Nau mai whakatau mai ki te wiki tuarua o ēnei mahi. Good morning everybody and welcome to our second week of hearings. Good morning Mrs Emma Finlayson-Davis.

MS FINLAYSON-DAVIS: Good morning Commissioners. The first witness today is Brian Stabb. He is being supported by his friend Nick Drury and assisted by counsel Lester Caldwell.

BRIAN KENNETH STABB

CHAIR: Before we start, welcome to you both. Morning. Do you mind if I call you Brian?

A. Absolutely not, no.

Q. Thank you and you are?

SUPPORT PERSON: Nick.

CHAIR: Thank you for coming and supporting Brian Nick, I'm sure he's very comforted by that. Just to let everybody know that this evidence will not be live streamed but will be uploaded to the website later on. And before we start, if I can ask you to take the affirmation, Brian, is that all right?

A. Mmm.

Q. Thank you. Do you solemnly, sincerely, truly declare and affirm that the evidence you give to the Commission will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you very much.

QUESTIONING BY MS FINLAYSON-DAVIS: Good morning Mr Stabb. You have made a statement to the Commission about your time working as a psychiatric nurse in the Lake Alice Child and Adolescent Unit and do you have that statement before you dated 22 April 2021?

A. I do, yes.

Q. There is also a supplementary statement dated 3 June 2021?

A. Uh-huh.

Q. And you have that before you as well?

A. Yeah.

Q. Now since you've left the unit you've made a number of statements over the years; is that correct?

A. Yeah.

Q. And we don't need to go through those in detail, they're set out until the written statement

that the Commissioners have. And it's probably appropriate at this point to let you know that both of your statements have been read in advance by the Commissioners, so if there are parts we don't cover today in your oral evidence, they're certainly before the Commissioners.

A. Mmm-hmm.

Q. In a moment I'm going to invite you to read out your statements to us. They set out your account of your time in the unit. I'm going to pause you at various parts, Mr Stabb, where I'll be putting to you for comment evidence that we have already heard, or evidence we may hear later this week which paints a different picture, perhaps, than the account you are giving this morning and I do that to give you the opportunity to comment on that evidence?

A. Mmm.

Q. And in light of the time that we have available, I may be summarising some of that evidence rather than taking you to individual accounts, is that okay?

A. Yeah.

Q. All right. Well, if I can ask you to pick it up at paragraph 5 of your statement, Mr Stabb, and as I say, I'll try to keep my interruptions to a minimum, but there will be parts where I ask questions as we go through.

A. I worked in the area of mental health for in excess of 30 years. I originally trained in England as a psych nurse beginning at 18 years of age. My qualifications are RMN UK 1971, RPN New Zealand 1973, registered comprehensive nurse New Zealand 1980, Advanced Diploma in Nursing Psych Option Auckland 1983, and a northern region teacher training certificate from Waikato in 1991.

I have held positions as a clinical nurse specialist, a nurse manager, a supervisor of district nurses, a nursing tutor, an educator and family advocate for the Schizophrenia Fellowship and I have a firm commitment to high standards of mental health care.

Early employment at Lake Alice, January 1974. I emigrated to New Zealand from England arriving on 5 January 1974. I commenced working at Lake Alice on 7 January and was initially assigned to villa 15. Villa 15 was home to long-term adult psychiatric patients.

When I first arrived at Lake Alice I heard stories that there had been some trouble within the adolescent ward and that some staff would be changed. These stories related to the mistreatment of the residents.

As I recall there was an external inquiry into allegations of mistreatment. The inquiry was conducted by a JP and a lawyer from Marton. They concluded that the

allegations were unfounded, being based on the "malicious accusations of the disturbed children who resided there".

Q. That quote is in speech marks, Mr Stabb. Do you know whose words they were?

A. I don't know, but I recall them, there was an article in the Rangitikei Times just outlining that there'd been an inquiry and that quote was at the end of the article.

Q. If you could pick it up again from paragraph 10.

A. Yeah. Whilst I worked in villa 15, I was sometimes, a lot of the time, called upon to relieve for lunch and dinner in the adolescent unit, which was comprised of villa 10 and villa 11. This was because staff worked 12 hour shifts and as part of my duties I was required to relieve the adolescent staff for meal breaks. I would often spend two to three hours a day there. Staff from the rest of the hospital were usually treated as outsiders by the adolescent staff.

Between 72 and 74 the adolescent unit had built a reputation of being set apart and clandestine. The staff who worked there were ostracised and none of the local staff wanted to work there. This is probably why immigrant staff such as myself tended to get posted there when they began working at Lake Alice.

Q. And on that, Mr Stabb, when you say immigrant staff, where were the staff coming from?

A. From England mostly, yeah. I responded to an advert in the English Nursing Mirror and I think, as a result, nine families of us emigrated to Lake Alice.

Q. That was nine families?

A. Yeah, and I think within two years seven had returned, I was one of the two that stayed.

Q. Thank you. Please continue.

A. I believe that Dr Leeks wanted to keep the operations of the unit hidden from the other staff at Lake Alice Hospital. Despite this, all of the staff had an idea of what was going on, though it was never really admitted openly.

Specific incidents which occurred while relieving - while I was relieving at Lake Alice. I've paragraphed it Black Friday, it's what the kids called it. I never personally saw or took part in the treatment programme, however the conversations I had with staff and residents as well as my personal observations led me to believe that a programme of Aversion Therapy was being practised, and that this included the use of the ECT apparatus.

I learned there was a culture of fear of what the kids would call Black Friday. This was when Dr Leeks would come to administer ECT. I would often be called upon to clear up the ECT machine and the mattresses and sometimes the soiled sheets that were in the rooms. I relieved on Friday afternoon around six or seven times.

On one occasion I was relieving tea about 4 pm. Dr Leeks was giving ECT treatment upstairs. I was asked to stay in the lounge downstairs with the residents.

I observed 10 to 12 of them watching a blank TV screen in the lounge. In those days TV didn't start until 5 or 6 o'clock. As the treatment of ECT was given upstairs, the residents downstairs could see shock waves across the television screen. On each occasion there were hoots and whistles and shouts of "give them another one" and "serves them right".

I cannot recall if I saw the interference on the TV myself but one of the residents told me about it afterwards. It was clear from the frequency of the residents yelling that this was not a standard ECT treatment. It lasted for periods of 15 to 20 minutes with around 20 to 30 separated shocks. Later I was sent upstairs to clean up the ECT room and the dormitory.

On another occasion I went into the lounge and there was a resident tied up into a laundry bag. This was in a thick canvass bag with a thick drawstring on top of it. I let him out. I can't remember his second name. He wouldn't speak and he wouldn't move without being led. I attempted to give him a drink but he couldn't hold the cup and any water would dribble out of his mouth.

When the staff returned from tea I asked what was wrong with the boy. I was told that he had behavioural problems and that this was part of his treatment. The staff member concerned returned him to the bag. On another occasion a short time later I let him out of the bag again. Nothing was said to me about that.

ECT as punishment to adult residents. On another occasion when I first started at Lake Alice I was approached by Terry Conlan who was carrying the ECT machine. He asked me to assist him in giving ECT to an elderly man from one of the adult wards. Dr Leeks had asked Terry to do this because he had found out that this man had been sexually interfering with Lake Alice Adolescent Unit patients during their leisure time on the cricket pitch.

I refused to do this because it was my understanding that nurses were not meant to administer ECT on their own. Terry Conlan was the staff nurse. I believe that Terry administered the ECT over in the recreation hall.

Q. Mr Stabb, are you aware of any other occasions where staff nurses would use the ECT machine on their own during this period of time?

A. I heard stories about how they applied (inaudible). Aversion Therapy at Lake Alice. 72-74. I'd had experience with Aversion Therapy in England prior to emigrating. I think

it's worth describing them in detail so that a comparison can be drawn with the Aversion Therapy programme in question at Lake Alice.

The first occasion was at Rainhill Hospital in Liverpool in the UK in 1966. Adult patients would volunteer for treatment. The time that I saw it being used was to treat the condition of homosexuality, which is then categorised as a form of mental illness.

The client would sit in front of a slide projector screen. In one hand he would have a box with a button on it and on the other wrist would be a bracelet with a wire attached. A series of photographs of naked men and women would be flashed on to the screen at regular intervals. The client was able to hold the pictures on the screen by pressing a button or he could recall a previous picture on the screen. Each time he held or recalled a picture of a naked man he would receive an electric shock to his wrist. This treatment would occur for hourly sessions twice a day for several weeks.

The second occasion I saw Aversion Therapy was in Cane Hill Hospital in Coulsdon Surrey. There was an inpatient facility for alcoholic clients. Again, all would volunteer to come on the programme which, as I recall, ran for six weeks. The lounge of the ward was done up like the inside of a pub complete with fully stocked bar. At certain times during the day the bar was opened, the nurse on duty donning a waiter's coat complete with bow tie. The clients would sit at the bar and don a necklace which was wired and ran under the bar to a control panel.

They would order drinks, whatever they wanted, and the first drink would go down without consequence. However, on the second drink the nurse behind the bar would wait until the client was in the act of swallowing and then would press a button giving the client an electric shock on the throat. I remember that some would cough and splutter at first, but they would soon learn to endure the discomfort and drink anyway.

As bizarre as these treatments sound, they were acceptable and legitimate within the context of the times. However, several things should be noted when comparing this with what happened at Lake Alice.

Firstly, they were all adult patients. Secondly, they all volunteered for treatment. Thirdly, the electric shock apparatus was a portable device powered by torch batteries. This was administered as an organised, documented and regularly monitored team process.

Aversion Therapy at Lake Alice. I never personally saw or took part in that treatment programme, but the conservations I had with staff and residents and my personal observations led me to believe that Dr Leeks conducted a programme of Aversion Therapy which included the ECT apparatus. I believe this occurred at the Lake Alice Unit between

1972 and 1974 and that it was practised on boys aged between 12 and 16 years.

The treatment would be called Ectonus treatment by Dr Leeks. I know of no treatment or knew of no treatment in psychiatry specifically described as Ectonus. If my memory serves me correctly, Ectonus was the brand name of the apparatus used to administer ECT, it wasn't a form of therapy.

Boys would apparently be taken from the lounge area to an upstairs side room which was dark, shuttered and when the door was closed, virtually soundproof. Sometimes this would be done forcibly.

Inside the room, Dr Leeks would administer electric shocks to various parts of the boy's body over a period of 20 minutes. A mouth gag was placed in the boy's mouth for him to bite down on whilst the shocks were administered.

During this time Dr Leeks would maintain a reprimanding-type monologue whilst the boy was held down by the nurses. At the end of time Dr Leeks would give a full unmodified ECT rendering the boy unconscious. The boy would then be taken to a dormitory area, placed on a bed and left alone to recover.

Q. Before you move on, Mr Stabb, just to clarify, what you've described for us is based on what you were told would occur during these sessions?

A. Yes, I witnessed the aftermath of it, the boys lying or semi-conscious and recovering.

Q. I think we got to paragraph 36.

A. The ECT machine, which was kept in the room, in the clinic, was conducted - had a twist regulator on it with which the operator could directly control the intensity of the current to the headset electrodes. I had never seen an ECT machine like this before and I've never seen it used this way. Further, I believe this was an improper use of the ECT machine.

I believe that this was done in a last ditch attempt to break patterns of extreme acting out which were seen as inevitably leading these young people into life sometimes of criminal, delinquent behaviour and institutional care. I believe that this was done without the consent of the individuals, most of whom, as I recall, were wards of the State.

The residents who spoke to me about it, about 12 in all, all told me consistent stories over a long period of time. They described it as torture in the sense that they would protest, resist, sometimes scream, as anybody would who was being tortured.

Some staff in fact boasted to me that they themselves had administered the electric shocks and that this had been approved by Dr Leeks in his absence. I believe that this was a significant role taken by some of the nurses who practised in the adolescent unit between 1972 and 1974. I heard about this treatment from Steve Hunt, Terry Conlan also.

I believe that this regime was conducted in an air of secrecy, it was neither documented, controlled nor monitored. There were no records kept by Dr Leeks, and there were no records of nursing procedures essential for the safe administration of ECT. Dr Leeks kept medicine charts but I don't recall ever reading a medical note written by him in all my time at Lake Alice.

I consider this to have been a barbaric and cruel practice, which would have been as damaging to those who administered it as it was to those who received it. I can only speculate as to the motivation and mindset of those who administered such treatment. Such practice was not in context with the times and it could never be argued as being so.

There is no way that this treatment could be rationalised in a civilised society as legitimate treatment. It was torture, nothing less. I believe registered doctors and nurses would recognise it in the same way.

Q. Now before we move on to the next portion of your statement, Mr Stabb, you've told us about your experience in England and what you observed of Aversion Therapy being carried out there?

A. Yeah.

Q. You've now described to us how different, and, to use your words, barbaric what you were observing in the unit or hearing about was occurring. Did you consider making a complaint at that point in time?

A. I thought about it a lot. Part of my conditions at Lake Alice of employment was that I had to sign the Official Secrets Act and I was, throughout my time at Lake Alice, I was under the impression that any form of whistleblowing would be - result in my prosecution under the Official Secrets Act.

Q. How was that information provided to you, do you recall how the position was explained when you commenced employment?

A. I don't recall that it was, only that the Official Secrets Act was explained to me and even though that was written for the security block patients, that it applied to all of the hospital because it was a Health Department institution. I agonised over this for - throughout the time I was working in the adolescent unit, which was two years. Eventually I ended up coaching a group of teenage boys about how to lay a complaint and they'd asked me about what they could do and I was aware as a nurse that there was a complaints procedure.

Q. I think we - that's covered in your supplementary statement, isn't it?

A. Yes.

Q. But from your point of view as an employed nurse, you felt constrained, is that what you're

saying, by the Official Secrets Act?

A. Yes, yeah. And certainly the Neil Pugmire thing happened which sort of reinforced that.

Q. Taking you off your statement for a moment, if we now return perhaps to paragraph 43.

A. Okay. In April 74 I was assigned to villa 11. This was part of a major change of staff in the unit. The new charge nurse was Dempsey Corkran. Terry Fountain was also assigned to villa 11. Initially the three of us formed the mainstay of the trained staff for Lake Alice.

I was in the unit for two years. During that time there were other staff members that came and went. It did not appear to me that the adolescent unit was a popular place to work. I believe there was a general feeling in the hospital that the residents were out of control and undisciplined.

There was a fairly low experience, in fact probably a very low experience, amongst the qualified nurses, of various aspects of psychiatric nursing. Most nurse aides had no training and were just placed in the unit and expected to pick it up and learn as they went.

Q. Just ask a few questions around that, Mr Stabb. You've spoken about your training prior to arriving in New Zealand at Lake Alice. Were there others like you with prior training, psychiatric nurse training in the unit?

A. Amongst the immigrant population, certainly all of those that emigrated were experienced nurses when we arrived here, I think I'd had close to 10 years in England in institutions.

Q. Sorry, you'd had 10 years in institutions prior to arriving in New Zealand?

A. Yeah.

Q. And perhaps if you can help us understand the difference between a psychiatric nurse, a nurse aide, and sometimes there are staff referred to as hospital aids, what's the difference between those roles?

A. Nurse aide and hospital aide I see as the same thing. A registered psychiatric nurse is somebody that's done three years training and has passed various exams and tests. A nurse aide is basically a lay person who's employed in the capacity as a helper.

CHAIR: Sorry to interrupt you, Brian. I've just had a note, it's important that I give a direction at this moment - nothing to do with you, so don't worry about it - directing the press not to report on the content of Mr Stabb's evidence at this stage. It's important that it remain within these four walls until further notice. So that's a firm direction to the press not to do any reporting of Mr Stabb's evidence while he's giving it until further direction. Thank you.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: Thank you Madam Chair. So a nurse aide you said was a lay person, so they could have come from completely different

backgrounds?

A. Yes.

Q. Was that the same across the Lake Alice Hospital to your knowledge, Mr Stabb, or just in terms of the adolescent unit?

A. No, it was the same across the hospital. There was the intermediary level, enrolled nurse, who trained for two years, but the hierarchy went staff nurse, enrolled nurse, nurse aide.

Q. So just to cover that, there was staff nurse, enrolled nurse and then nurse aide?

A. Mmm.

Q. And presumably above all of that was a charge nurse?

A. Mmm.

Q. Thank you. Perhaps if we go back now to paragraph 46.

A. Around July 76 we moved from villa 11 to villa 7, which was a much larger building with about 36 beds. The treatment programme grew accordingly and included regular group therapy sessions, which were sometimes facilitated by Dr Leeks and Vic Soeterik, a regular visiting psychologist from Palmerston North.

CHAIR: When you say "we", Brian, do you mean that the child and adolescent unit moved from 11 to 7?

A. Yes.

Q. The whole unit physically moved?

A. Yes.

Q. Okay, thank you.

A. At the time up-sizing the unit seemed like a good idea. Dempsey and Dr Leeks both supported it. However, in hindsight I believe the number of residents was too much to manage and provide meaningful support to.

I became very involved in the group therapy process and Dr Leeks and Vic Soeterik spent many hours coaching and supervising Dempsey and myself in this area. Another visiting psychologist I remember was Craig, I've written McDonald here but I think his name was Jackson, although I think he was more involved with educational issues rather than clinical issues.

Later, group discussions became a regular part of the weekly routine. As I recall, the approach was essentially psychoanalytical being based around the assumption that insight led to behaviour change. Dr Leeks was very Freudian in his approach.

Q. I think at this point you move on from the group therapy sessions, Mr Stabb, although I think you come back to them perhaps later on?

A. Yeah.

Q. But this is an example of putting some evidence to you for comment. A number of survivors have described that failing to engage in these group therapy sessions to contribute would lead to either the threat of ECT or in fact the application of electric shocks. Was that something you were aware of?

A. In terms of the aversion aspects of it, ECT, I really don't know, I wasn't there when that was happening, but in terms of ECT as a treatment for depression it would be true to say that Dr Leeks would use his observations in groups of the children to formulate his treatment programme.

Q. Do you remember that being discussed in the group therapy sessions?

A. I remember subsequent to a group therapy session there would be a staff meeting and Dr Leeks would comment on people who were withdrawn and who would appear depressed to him and ECT would sometimes be prescribed.

Q. If we take you back to paragraph 50.

A. Yeah. Sometime later female adolescents who resided in villa 6, which was the adult admission ward, were integrated into the day programme at the adolescent unit. This brought the numbers in the programme up to 45 or so at times. A large number of the patients were wards of the State. Dr Leeks duly assumed guardianship and carried out treatment that he felt appropriate. It was very unusual for parents to visit the unit and it was unusual for Dr Leeks to interview parents.

Q. What about the ability of patients to call their families or to write to their families, can you comment on that during your time in the unit?

A. Certainly in terms of writing to their families they were letters - they could write letters would be posted. In terms of contacting the families, it wasn't a thing that happened very often and to be - to go by memory it wasn't something that was requested by the kids very often either.

Q. And the letters that the patients would write, would they be read by the staff -

A. Yes.

Q. - before they were sent?

A. Yes, yeah, they would be sent.

Q. Paragraph 52, thank you Mr Stabb.

A. The administration of medication was a normal routine in the adolescent unit. At any one time the maximum number of nursing staff during the day was four. It was considered to be a national facility and referrals came from all over New Zealand, even one or two from

overseas.

The adolescent unit under Dempsey Corkran. Dempsey Corkran was in my mind one of the most progressive charge nurses to work at Lake Alice and I really believed that he believed he could straighten out the place. Prior to his arrival, I believe the unit was a much worse place to be for the patients. He was given more free reign than a charge nurse usually would

One of his initiatives was creating a programme of behaviour modification which was reward focused. It involved a system of daily assessment of each individual young person's behaviour. Specific behaviours were given in A, B, C or D grading at various times during the day. This related to all aspects of daily living such as bed-making, personal hygiene, dress and grooming, dining habits, schoolwork, personal chores etc.

At the end of each week, a points system would be toted up and various rewards such as cinema trips, lollies, canteen vouchers etc would be divvied out to those who excelled. Progressive improvements would result in periods of trial leave. At the other end of the scale, an accumulation of Ds during the day would result in certain penalties such as going to bed early or extra chores.

Q. We're going to come back to this programme, you address it later on again, Mr Stabb, and we'll look again at what happened when Ds were received. But perhaps if you can continue on at paragraph 56.

A. I believe that the culture at Lake Alice during my time there with Dempsey as the charge nurse was a caring one. The mainstream staff were committed to doing their absolute best to help a group who were not well serviced by the mental health care system. It was very much a family type environment with the regular staff being cast in family roles.

One instance of positive change I recall was Dempsey working with a particular boy encouraging him to place himself in time-out when he got worked up and aggressive. By the end of my time there this lad would go to his room without a fuss when he required to calm down.

This - I look at this paragraph here and I feel almost fraudulent in saying it, but I've been following the Inquiry and I've heard some of this heart-breaking testimony of survivors and this seems incongruous, but it's true. In many ways between 74 and 76 it was a therapeutic community, quite in advance of its time and I was deeply saddened to see it so denigrated and maligned in the years that followed its closure.

Typical day at the Lake Alice Adolescent Unit. The day would start with the nurses heading upstairs to get the kids up to wake them and to get them to make their beds.

Following our grading assessment of their bed-making, we would take them to breakfast before giving them medication between 8 and 9.

From 9 o'clock until 11.30 most residents would go to school. Some of the more difficult children would remain in the unit. They would return from school around midday for lunch before heading back to school or having leisure or sports time.

Q. Just before you move on from there, Mr Stabb. We've heard some evidence, and I anticipate we'll hear more evidence this week from survivors that in fact schooling was sporadic, perhaps a day here or there, or a half day. What's your recollection of the schooling or what do you - do you have a comment to their evidence on that?

A. I can see how that would be the case. Children were often kept back from school for doctor's rounds, you know, Selwyn Leeks would come, any of the things that were routine things that were to do with the running of the ward and the kids would probably take precedence over being at school, so I could easily see how it would have been seen as sporadic.

Q. In respect of some survivors, we've certainly received statements where they don't recall attending school at all. Do you have any comment on that? Were there children that weren't going to school at all?

A. There were a few that didn't go to school because of their behaviours basically, so unmanageable. But not many. The school was very small, it was what had previously been an old 50 bed villa and, as I say, the numbers in the unit at its peak were well over 45, 50, so that would be another big constraining factor.

Q. I think you were at paragraph 61.

A. From 4 o'clock onwards the nurses would take group sessions with the residents as well as play various games and events or watch television. In these group sessions we would talk to them about their personal issues, covering how they were getting on. They didn't talk about the complaints at Lake Alice. If they complained about anything it would probably be due to the separation from the home and family.

Between 9 and 11 residents would go to bed, depending on their age. There would be one staff member on duty overnight. The door to the unit would be locked at night and it was unlocked during the day. Apart from seclusion, there were not many locked doors used. This is because not many kids tended to run away, as Lake Alice was really isolated and often residents came from outside the immediate region.

There was a mix of residents and I don't recall a referral ever being turned away. Some were behaviourally disordered due to early abuse, others were mentally ill in the

traditional sense and displayed all the signs of florid psychosis. There was a small group who were intellectually challenged.

I believe that around half of the residents had more behavioural issues than actual psychiatric disorders. There were definitely some patients who did not belong there but had nowhere else to go. I think that CYFS thought Lake Alice was a great place to unload difficult cases.

Q. And in the 1970s CYFS would be Department of Social Welfare. If I can take you now to paragraph 82.

A. The use of electroconvulsive therapy at Lake Alice 74 to 76. Right from the outset of his employment, Dempsey made it clear that treatment would involve no form of physical punishment or use of ECT other than the legitimate form used in mainstream psychiatry as prescribed or administered by a psychiatrist at the time. Dr Leeks was responsible for this. It is my understanding that one of the conditions simply laid down when he took over the unit was that he would not allow unmodified ECT that was not therapeutic.

ECT was usually prescribed for residents diagnosed with depression and sometimes schizoaffective disorders.

Dr Leeks usually came to the adolescent unit on a Friday and ECT treatment was scheduled for then. Occasionally he would visit on a Monday. This scheduled treatment was usually modified, given after the administration of an intravenous anaesthetic, muscular relaxant and the modified ECT often occurred in villa 6. The girls were given ECT in villa 6 and the boys in villa 7 from memory. Certainly if it were to be modified, ECT, as all the anaesthetist equipment was in villa 6, and this was traditionally where the anaesthetist worked.

During an ECT treatment, Dr Leeks and two nurses would be present, sometimes with a second doctor or an anaesthetist. There would not usually be any external visitors or staff in training.

The nurses would restrain the patients during ECT treatment. They were also responsible for maintaining the patient's airway. We were to stay with the patients after treatment until we felt they were recovered, which meant that they were fully conscious again.

Q. And just before you move on to the unmodified ECT treatment, when it was given in a modified fashion and you talk about the recovery process, where that would take place?

A. In villa 7 it would take place in their beds upstairs in the dormitory. If I go back to my earlier experience of villa 11, again, the ECT would take place in a side room and then they

would be moved to a dormitory at the end of the corridor to recover, and there would often be five or six boys in bed recovering from sessions of ECT.

Q. With the modified ECT you've told us that the equipment to do modified ECT only existed in villa 6?

A. Yes.

Q. So when you mentioned villa 7, that's presumably the unmodified sessions we're about to talk about?

A. Yes.

Q. So when the modified session occurred in villa 6, is that where recovery would also take place in villa 6?

A. Yes, the boys I don't believe ever went to villa 6 for ECT, I think it was just the girls had ECT in villa 6. During my time any ECTs for boys were done in villa 7.

Q. How were boys able to have modified ECT in villa 6?

A. In villa 6?

Q. Sorry, in villa 7.

A. They would, as I say, all the anaesthetic equipment was in villa 6. So it was unmodified ECT I saw in villa 7.

Q. Were you ever present in villa 6 for unmodified ECT session?

A. Villa 7, yeah.

Q. No, in villa 6, did you ever go to villa 6 for a modified ECT session?

A. Oh, yes, I'm trying to remember, I believe I did, yes, on a couple of occasions.

Q. But it would seem the majority of your recollection is in relation to villa 7?

A. Villa 7.

Q. Where it was unmodified?

A. Yes.

Q. I think that's a time to pick up from paragraph 87.

A. Sometimes ECT treatment was not scheduled in advance and if Dr Leeks considered it necessary, it would be given in villa 7 unmodified, that is the direct administration of high voltage electric shock to the head causing instant unconsciousness and seizure. I witnessed about a dozen unmodified ECT treatments in villa 7.

Q. Can you comment, Mr Stabb, on the circumstances which gave rise to an unscheduled session of unmodified ECT?

A. If Dr Leeks interviewed a child and felt that it was urgent for them to have ECT he would do it sometimes within an hour's notice of seeing the kid and that would happen in villa 7.

Q. And when a session of unmodified ECT occurred in villa 7, you've spoken about what the staff requirements were for a modified session, I think, what were the staff requirements if it was unmodified?

A. First of all to prepare the kid for the ECT, which would be to talk to them and explain what was going to happen and what the treatment entailed. Then they would go upstairs and they would lie on their beds and Dr Leeks would bring the ECT machine beside the bed and would give a full unmodified ECT which would cause instant unconsciousness.

Q. And how many staff would be in the room?

A. A couple. When someone has unmodified ECT they will flail about their arms and legs and there's a danger of fractures and various other injuries, so they have to be restrained in a particular way, that is the knees and the joints have to be secured. In unmodified(sic) ECT that's not necessary.

Q. Sorry, in modified?

A. Yeah, in, sorry, in modified ECT.

Q. It's not necessary to restrain?

A. Yes, it's very, very seldom. There would be a faint twitching, you may see the abdomen moving and the hands and legs twitching, arms twitching, but there wouldn't be a wild flaying about of limbs like there sometimes could be in unmodified ECT.

Q. And during those unmodified sessions, whose job would it be to restrain the patient?

A. Nurses.

CHAIR: Could I just ask a question here of you Brian?

A. Yeah.

Q. We've heard some evidence from some survivors that they were strapped down, that they were leather straps held them to a bed or whatever. Did you ever see that or know of that practice what happening?

A. I'd heard of it happening. I never saw it. I can only assume that in those first few years, 72 to 74.

Q. Before your time?

A. Yeah.

Q. All right, thank you.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: I think if we pick it up from paragraph 88, Mr Stabb.

A. For unmodified ECT, one treatment or application of ECT would be given for about 5 to 10 seconds. Once seizure was achieved the treatment was completed.

Unmodified ECT is not an easy or pleasant business to view or, assist with. The patient's shoulders and knees had to be restrained to avoid injury as the convulsions were often quite violent. They would sometimes yell and scream. Any claim that unmodified ECT was quick and painless isn't true.

After an ECT treatment, it was like the patient had been hit by a train. They would be confused, disorientated and their limbs would ache. And they'd sometimes be incontinent.

Two youths that I remember who presented as solitary withdrawal individuals, IT appeared that they had depressive illness, were given unmodified ECT. And it didn't seem unusual to me at the time for those particular boys, that ECT should be given.

On these cases they were given an explanation of the treatment and the reasons for it by Dr Leeks and both of these boys cooperated. I'd never felt comfortable about unmodified ECT but I had seen it in England, and only as a legitimate form of treatment, and I considered it part of my nursing duties.

It's probably worth mentioning that in the early 80s a male nurse was struck from the register of nurses in England for refusing to take part in ECT treatment.

I recall finding it peculiar that there was a lack of medical notation by Dr Leeks. I don't recall notation of the visits that he paid to the unit. However, during my time there Dempsey updated many of the protocols, particularly the documentation of ECT.

Nursing notes were also taken, covering what had happened and why treatment was being given. However, these were not always kept well.

Unless the child had been committed under the Mental Health Act or was a ward of the State, I would have expected consent to be obtained from the child's parent or guardian prior to them being given ECT or a course of Aversion Therapy. Consent was not usually an issue raised during my time at Lake Alice.

Q. Before you move on to speak about a particular incident, Mr Stabb.

A. Yeah.

Q. We've heard from survivors over the last week that even after 1974 and after Dempsey Corkran's arrival the use of painful electric shocks and Paraldehyde for punishment continued. We've heard that they would have to be manhandled or dragged up the stairs to receive the treatment. And if I can perhaps take you to a portion of the evidence we've heard and I'll invite your comment on that. This was from Mr Hendricks last week and it's paragraph 19. If I can just read that out to you. Mr Hendricks I note was in the unit following Mr Corkran's arrival:

"ECT was regularly used as punishment. The ECT machine would be wheeled into the dining room to scare us into being good. As soon as we saw the machine everybody stopped talking and we would be silent. The only reason for the presence of the ECT machine was as a threat of punishment.

Paragraph 20. From the dormitory where I was placed you could hear the screams of boys being given shock treatment. I regularly saw boys being dragged off to the ECT machine for punishment. I am quite sure that it was punishment and not part of treatment. I wasn't stupid and could put two and two together. I saw people misbehave, saw them threatened with punishment, saw them dragged away, heard their screams and could see the heat marks left on their legs around the knee area when they returned. The marks were described to me by the boys involved as being from the electrodes."

And before I ask you to comment, there's one other aspect of evidence that we will hear later on today, and that is from a nurse aide, Gloria Barr. Paragraph 42, again Ms Barr, I should clarify, was in the unit following Dempsey Corkran's arrival:

"It was common knowledge among the staff in the unit that ECT was given as punishment. The kids knew this as well. Whenever a patient was taken upstairs, the rest knew what was going to happen. It was awful."

Mr Stabb, are you able to comment or reconcile those accounts with what you've described as a change in approach with Dempsey Corkran arriving in the unit?

A. In my experience and time in the unit, ECT was given unmodified by Dr Leeks. Some of those incidents of unmodified ECT were unsavoury to say the least.

Q. Unsavoury?

A. Yeah. In terms of it being an organised punishment, that did not happen. That did not happen. In terms of the ECT machine being displayed to the kids, that did not happen. None of us would have done that. I wouldn't have done it, none of the regular staff would have behaved in that way.

However, I believe such things did go on prior to Dempsey Corkran's era, yeah. I can easily see how, once something had been labelled as a punishment, it's very hard to see it as treatment. I think any - I remember other injections were given other than Paraldehyde. I think any injection at the time was seen as punishment, as indeed any ECT treatment was seen as punishment, because of the precedent set by the earlier regime.

Q. I think you were about to move on to telling us about a particular incident of unmodified ECT you witnessed, paragraph 96.

CHAIR: Before you do that, just to clarify what you've just said, are you saying that once

Dempsey Corkran came there was no use of ECT as an organised form of punishment?
A. Yes, I'm saying that very clearly. I didn't observe that.
Q. You didn't observe that or understand that was the situation?
A. I saw unmodified ECT, unsavoury incidents like the one I'm going to describe, but no -
Q. But you didn't think that they were part of an organised punishment regime?
A. No.
Q. Could they have been seen as sort of one-off spontaneous applications for punishment? I think you said that Dr Leeks would talk to one of the patients and then within an hour would -
A. Yeah.
Q. - would administer.
A. I think it's worth remembering that Dr Leeks spent very little time in the unit, one day a week if we were lucky, it was a 24-hour a day, seven days a week unit, and he would - his time there would really give him very little time to either assess a child's mental state, and that very small time he would use as a way to decide whether or not someone was going to have ECT.
Q. So just talking about those specific occasions, he didn't spend a lot of time there, he would come in, he would, on your - what you've told us is that he would come in, he would talk to one of the patients, for example, and then within an hour he would administer unmodified ECT?
A. I have seen things like happen, yes.
Q. So my question is, so that's not organised, but do you know if that was regarded, that sort of incident was regarded as punishment?
A. I can easily see how it would be regarded as punishment.
Q. Are you saying from the survivor's perspective?
A. Yes.
Q. They could see that?
A. Yes.
Q. Did you also say, because I didn't quite hear you, that some of that perception might have come from the previous regime?
A. Yes.
Q. So that whatever Dempsey Corkran was doing, the patients were still seeing it as being punishment?
A. Yeah, the culture was still prevalent.

Q. Thank you for clarifying that.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: So paragraph 96 Mr Stabb.

A. I recall one particular incident around 1975 where a youth had ran away from the unit to his home in Foxton. I knew him well and had a good rapport with him. From my perspective he had not presented as depressed in any way at all. He was an active, boisterous 15 year old boy, always involved, not at all withdrawn and quite sociable.

Dr Leeks had visited the unit and had conducted a 10 minute interview with him. He had been returned to the unit after running away and Dr Leeks had, on the strength of that 10 minute interview, had decided to administer unmodified ECT. He said that it was for depression.

The boy didn't cooperate and he had to be restrained. It was a prolonged episode in which he broke away from us at one point and we had to chase him through the villa. During the chase I recall Dr Leeks running around the dormitory with the ECT machine under his arm. And he was joking with us all in the process. It was bizarre.

When the boy was caught he was taken upstairs fighting and screaming and he was given unmodified ECT. The whole incident had been deeply distressing for me. It left me shaky, nervous, giggly and close to incontinence. Immediately afterwards I approached Dr Leeks expressing my discomfort and querying the treatment.

In response, he reprimanded me and told me very clearly that it was not my place to question his clinical judgment and that if I continued to do so he would arrange to have me transferred to another villa. He also told me that I should consider my position in the hospital and my reliance upon hospital housing in the light of the fact that I had a young family.

I was very much affected by this conversation, which is why I recall it so clearly. Following this encounter, I was never on duty again when ECT was given. My relationship with Dr Leeks was also affected from that point onwards.

A few weeks after the incident I was transferred to the maximum security villa at Lake Alice. Dr Pugmire and myself thought it would be a convenient transfer. Dempsey also thought it was time for me to move and have a break from the unit.

I don't believe it was a direct result of me questioning Dr Leeks that I was moved. However, if I had wanted to take things further, my only option would have been to go public. An internal complaint in hospital would not have gone far as in those days you would have been sidelined and moved from the hospital.

ECT as punishment in a grading system. ECT was never given as a punishment

for getting a D in Dempsey's grading system. If you got a D you would instead lose privileges and other benefits in order to motivate the residents to try better the next day.

Q. Just at that point, Mr Stabb, I'll get you to pause there. We - the Commission has received a statement from a former teacher at Lake Alice school, Anna Natusch, do you recall?

A. Yes, I recall Anna Natusch.

Q. She's given a statement and comments on the paragraph that you have just given.

A. Yeah.

Q. I want to bring that up on screen and to give you the opportunity to comment on that. So this is a statement made by Anna Natusch, 24 March 2021.

A. Yeah.

Q. And if we could go to paragraph 90 please. You'll see there, can you read that okay, Mr Stabb?

A. Not very well.

CHAIR: We can make it larger.

A. Oh yeah, I can read.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: We can call that out and I'll just read that out as well. "Psychiatric staff organised a behaviour modification system called the D system. The teachers were asked to rate a pupil each day on grades A to D and record the rating in a book. This sort of system is accepted in psychology and in psychiatry. Normally low marks would result in a child being deprived of lollies or being sent to bed early. I think the usual systems like this are excellent. Used mildly, it could be described as a kindly method of discipline."

If we could move to paragraphs 91 and 91:

"At Lake Alice, however, I would be loathe to give a D because I was aware of the dire consequences for the children. I was told upon being given the book that if a child had a small number of D ranks in a row, they would get electric shock treatment without anaesthetic. It was appalling.

92. They would get a D grade for mainly naughty or trivial things. I remember a nurse shouting 'D, electric shock treatment for you' when Hake - and we've heard from Mr Halo last week - playfully threw a piece of fluff at her crying out 'mouse'."

Do you have any comment on Ms Natusch's recollection of how the behavioural system worked, Mr Stabb?

A. I find that hard to - to understand how she could come to those conclusions. The reward system was devised by Dempsey and it was - there were actually no punishments

whatsoever in terms of - and for ECT to be cited as a punishment for getting a D is a -

Q. You haven't heart of that?

A. I know that that never happened.

Q. All right, if we can pick it up again at 105.

A. If residents were regularly getting Ds, Dr Leeks could prescribe ECT on the basis that the repeated poor performances were indicative of psychological symptoms that ECT was appropriate for. That would have happened, he would look at the patterns of A, B, C and Ds and incorporate them into his appraisal of that kid. It's possible that, you know, he would then give unmodified ECT, but it wasn't punishment, and to label it as punishment for getting a D is not true.

Q. Perhaps, though, that paragraph gives some context to what Ms Natusch was saying?

A. Yeah.

Q. That there was a connection between getting Ds -

A. Yeah.

Q. - and perhaps a treatment of ECT as a result of a number of them?

A. I could certainly see how it could be interpreted that way, yeah. But it wasn't in terms of the whole objective of the programme, it just wasn't that way, it didn't happen.

Q. If I can take you back then to, I think we're at paragraph 106.

A. I recall hearing about ECT being applied to the genitals and arms of patients. I don't believe this would have happened during the time that Dempsey was in charge of the unit. On one occasion I tried the ECT machine on myself, on my arm and it hurt. I can't how imagine that would feel on someone's genitals.

The use of Paraldehyde intra-muscular injections in the unit.

Q. Sorry, Mr Stabb, just before you start, I'm just conscious of the time. There is a little way to go with this witness. Shall we continue or would you prefer we take a brief adjournment?

CHAIR: Do you feel like taking a break?

A. I'd love to have a break.

Q. Right, you are the most important person in the room at this moment and we will do that. I think it's appropriate, we've been going for some time, we'll take 15 minutes at this stage.

Adjournment from 11.28 am to 11.53 am

CHAIR: Just before we commence, I'm told there might be some confusion about the direction I made before about publication. Just to be absolutely clear, that until Mr Stabb has finished his evidence there is to be no publication of his evidence, whether that's oral or

written. It's embargoed until further order but I can assure you that will occur if not before lunch then very shortly after lunch, so it will finish at that stage. So that's just a matter of clarification before we start. Thank you.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: Thank you ma'am. I think we got to paragraph 107, you were just about to talk of the use of Paraldehyde injections -

A. Yeah.

Q. - in the unit.

A. Paraldehyde was a drug I had seen used copiously in England. It was preferred by psychiatrists because it was very fast acting, it was safe and had very few side effects. However, it was a painful injection to receive.

At Lake Alice there was a standing order in every ward signed by the medical superintendent for intra-muscular Paraldehyde in emergency situations when sedation was needed for disturbed behaviour. The prescription sheet for the same was at the front of every ward medicine chart and it was signed by Dr Leeks. It was a practical, well-intentioned script designed for the realities of life at Lake Alice. Unfortunately such blanket prescriptions gave rise to abuse.

I believe it would not be prescribed by a blanket prescription for episodes of violent and aggressive behaviour nowadays. However, back in that time it was quite usual and acceptable. The standard dosage range was 2 to 10ccs. The amount you chose to administer depended upon the state of the patient.

Q. Mr Stabb, in relation to the purpose for giving these injections, you've mentioned violent and aggressive behaviour. Can you help us understand what that would look like in the unit?

A. How it would manifest?

Q. How it would manifest.

A. Yeah. Well, I'm just trying to think of an occasion, yeah, an occasion when I gave an injection of Paraldehyde was when one boy, I caught him holding the arm of another boy against a red hot radiator burning him. At the same time he had his hand, other hand over his mouth while he was pressing one hand on the radiator. And I intervened and he became very aggressive. And I remember giving that boy a Paraldehyde injection.

It's difficult to separate out the word punishment and draw a clear-cut line where this is disturbed behaviour. For the sake of the adolescent unit, when there was a real crisis sort of situation where fists were flying where danger was, you know, there was a dangerous situation, and a boy needed to go to sleep in a quiet room for 10 minutes, or

maybe half an hour, then it was an appropriate use of Paraldehyde. But other drugs were given as well. Paraldehyde wasn't the only drug that was given intra-muscularly for disturbed behaviour, yeah.

In terms of as a nurse, my responsibility when it came to Paraldehyde, first of all was to - you couldn't give it in a plastic syringe because it would dissolve the syringe, believe it or not, it had to be given in a glass syringe, glass and stainless steel syringe, which we had to autoclave in the ward between every injection.

In terms of my responsibilities I was - I had to establish the prescription was properly written by the doctor, that the dosage of the injection was clear, that the frequency of the injection was clear, whether it would be repeated within an hour or two hours or four hours or what have you, and that the injection technique itself had to be done properly.

In the case of Paraldehyde, it had to be given in the biggest muscle of the body which is gluteus maximus, backside, and it had to be given to the upper outer quadrant of the backside because the sciatic nerve rolls down the spine and there's always a danger you could hit the sciatic nerve.

There was - about technique, the worst technique in my experience is when the nurse puts a needle against the flesh of someone going to have the injection so they feel the pressure of the needle before it actually goes in. That causes inevitably the leg or the limb to tense and it becomes that much more difficult to put the needle in. A much better technique is to hold it up, maybe 4 inches, 6 inches away from the area you're targeting and then to deftly put it in, straight into the muscle without any real touching the leg or backside before it. Yeah, so that was particularly important with Paraldehyde because it was such - it was a painful drug, it stank when it was being forced in by the syringe.

Q. We've heard, Mr Stabb, last week, and I imagine we'll hear this week, of Paraldehyde injections being given for a variety of reasons, such as boyish behaviour, smoking, throwing apples, insolent remarks, and this taking place after 1974. Do you have any comment to the administration of Paraldehyde in those circumstances?

A. Certainly not in my experience in Dempsey's regime, it wasn't given. There was an awful lot of nursing notes written by myself and Dempsey Corkran. Screeds of nursing notes that have somehow disappeared and it's really unfortunate because a lot of - one of the things I would do with any injection, I would do a written account of what the injection was given for or go in the nursing notes, and there would be a variety of different sort of situations it would cover. But it certainly wasn't given for things like throwing apples or swearing or smoking. It was when things were getting pretty critical and danger, there was a danger to

somebody or other. And as I say, it was a very convenient drug because it acted very quickly, didn't last very long. I can still smell it when I talk about it, it had a distinctive smell.

Q. And I think at paragraph 112 you note that if it was given for smoking, that would have been inappropriate?

A. Yeah, yeah.

CHAIR: Just following on from that, you were shown some notes where it was thought it was your signature.

A. Yeah.

Q. Giving the Paraldehyde for smoking.

A. That's right.

Q. It wasn't your signature?

A. No, it was somebody with the same initials as myself.

Q. Right, but do you accept then that there is probably some other nurses who might have administered it in circumstances that you wouldn't approve of?

A. Yeah, I think it was a hang up from the old regime, if you like.

Q. Yes.

A. It was hard to break that culture. It's really clear now how firm that culture was established.

Q. Yes, thank you.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: Following on from the Chair's questions, in respect of your own use of Paraldehyde, where there are allegations that you have given it for reasons other than controlling out of control or aggressive behaviour, do you have any comment to make in respect of those allegations?

A. When I look back it was used as a way of control, controlling adverse behaviour. There were times when 30 boys can almost act together to behave in the most frightening of ways and it might well be that one boy would be causing that change in the climate, if you like. And it might well be that that boy would be seen as behaving in a disturbed manner and in need of sedation.

Q. I think at paragraph 114 you recall an incident of the use of Paraldehyde that you were troubled by?

A. 114 sorry?

Q. Paragraph 114.

A. Uh-huh. Yes indeed, yeah. I believe that happened at school camp. I remember the name of the girl, it was standard practice that as a male I wouldn't give injections to females and

any female that needed an injection would go back to villa 6 and it would be done by a female nurse. But I was on school camp and one of the nurses, Terry Conlan gave a girl an injection in a dormitory where there was eight or nine boys and a few other girls, the school teacher was there, but he - her trousers were lowered and her backside was exposed in the environment. I was really uncomfortable about how that was done, she was a 14 or 15 year old. I remember that happening very clearly.

Q. We're going to move on to some comments you've made about various other aspects of life in the unit, Mr Stabb. At paragraph 116 you talk about your understanding of the use of seclusion?

A. Yeah. During my time in Lake Alice under Dempsey we would usually not use seclusion for longer than an hour. I do recall a couple of occasions where a patient would spend a morning or afternoon there. Dr Leeks could prescribe seclusion, but I don't recall that happening.

Q. And again, your response to evidence that some survivors say they spent longer than a morning or an afternoon there?

A. Are we talking about this era?

Q. After 1974.

A. I don't know that that's the case, I don't believe that's the case. Dempsey was really firm about the use of seclusion and he would actually go and take boys out of rooms if they were in over the hour, he'd make a point of it.

Q. In the interest of time, Mr Stabb, we might move on to paragraph 119.

A. Yeah.

Q. This was an occasion of group therapy that you recall?

A. On an occasion of group therapy I recall Dr Leeks administering an intravenous injection of what I understood to be Methedrine which was used similar to Pentothal, which is a truth drug sort of thing, it was given to a patient as a form of abreaction therapy. Dr Leeks gave this intravenously in the clinic then immediately took the boy into a group therapy session and he sat there petrified in silence throughout the session, under the influence of this intravenous drug.

Q. Did you understand what the point of that administration was?

A. I've seen abreactions before but they'd been always given in a one-on-one situation closely monitored and supervised, and I've never seen it done by literally giving the person a drug and then placing them in a group environment, that seemed to me really off the wall.

Q. What was the purpose of such a drug?

A. Dr Leeks obviously believed that this boy had something hidden deep inside him that he would abreact him and that it would be revealed and subsequently insight would leave to behaviour change blah de blah.

Q. Paragraph 120 onwards you talk about violence had the unit?

A. Yeah. Violence did occur in the unit and I witnessed it on a number of occasions. At times there were over 30 or so youths, many of whom had histories of violent acting out, so inevitably there were incidents of bullying and fighting amongst them. But this was minimal.

On the occasions when it happened we would separate the combatants and they would each spend time out in seclusion, 30 minutes to an hour, no longer, and that would be duly recorded in the nursing notes. On the occasions when this violence was of a particularly serious nature, Paraldehyde would be used, but such occurrences were relatively rare.

It should be noted that on such occasions there were often just two male staff on duty. There was no alarm system. There was no training in calming and restraint, there was no training in de-escalating procedures, or the process of defusing incidents. There was also no process of debriefing staff after such violent incidents occurred.

I don't believe that there were any - that there was any sexual abuse between male and female patients as they were too closely monitored. However, it could have happened between male patients. I believe that it happened during the pre-Dempsey era and that Dr Leeks would have responded with Aversion Therapy.

At no time did I see or hear of any incidents of deliberate beatings or physical abuse being perpetrated upon a resident of the Lake Alice Unit during my time as a permanent staff member. Occasionally there were attacks upon staff, but such incidents were dealt with in a professional and civilised manner and they were duly recorded. Cruelty and abusive behaviour by nursing staff was simply not a part of the culture and would not have been tolerated by Dempsey or any of the mainstream staff.

I recall a time when a kid threw urine over Dempsey and he reacted very professionally, dealt with it very calmly to his credit.

Q. Can I ask you, Mr Stabb, in terms of the staffing rosters, would you work on set days, were there different staff that worked at night or was it the same staff that were present during the day?

A. Yeah, it was a four on two off roster. And the rosters had built in overtime(?). So your first two days would be from 7 o'clock in the morning until 7 o'clock at night, it was a 12

hour shift, and your second two days would be from 7 o'clock in the morning until 5 o'clock in the afternoon. And that was the standard arrangement and with the regular staff there would be a pattern of who was on and who was off at any particular time. But -

Q. What about the nights, who covered the nights?

A. The nights was a hodgepodge of staff around the hospital and it could be anybody from around the hospital. There was only one staff member on at night and 36 kids sometimes.

Q. So in terms of the regular staff where you've described the four on two off roster -

A. Yeah.

Q. - were the regular staff on at night?

A. No, no.

Q. We'll pick up at 126.

A. Okay. John Blackmore sexual abuse. Subsequent to my departure from Lake Alice I recall hearing rumours about incidents of sexual abuse that John Blackmore committed against residents. I can easily see how this happened, John was very effeminate, he was a big lad in his 50s. I understand that Dr Pugmire removed him from the unit and reinstated him in an adult unit. I only heard about that years later. I do not recall any other incidents of staff sexual abuse during my time.

Q. Paragraphs 128 and 129 confirm that you were aware on two occasions of patients being placed in the maximum security villa?

A. Yeah.

Q. And you note that you don't believe Dempsey would have been happy about -

A. No.

Q. - that?

A. No, not at all.

Q. I'm going to move you on to paragraph 132.

A. Yeah, experience of staff, Dr Selwyn Leeks. I knew Selwyn Leeks well and I have already expressed my abhorrence at some of the methods I believe he employed as treatment prior to April 74, namely Aversion Therapy. I also believe that his use of unmodified ECT during my time there was sometimes questionable and on the fringes of acceptability even for those times.

I believe, however, that he had a genuine concern for his charges. This sounds incongruous, but I believe that he considered the treatment he employed to be a last ditch attempt to change the lives of young people whose previous abusive history had them destined for lives of misery and tragedy. He considered many of them to have been written

off by both family and society. In the early 70s the cyclic nature of childhood abuse and its profound significance on adult behaviour was not as fully understood and considered as it is nowadays.

I personally think that Selwyn Leeks put himself above being personally affected by administering such treatments and in so doing failed to recognise the development of his own sadism and that of some of his staff. There was no such thing as supervision back then, so he did not have the input or oversight of other psychiatrists.

On occasions I experienced him as omnipotent and unreasonable. At other times I experienced him as a quiet, gently spoken man who, when he visited the unit, would spend hours with the residents both in the group and individual situations. Sometimes the children would even welcome him into the unit and follow him around.

He took a personal interest in my further education and he spent hours with the staff of villa 7 both in a supervisory and educational capacity. This was by no means the norm for psychiatrists of that era.

Q. I'll take you now, Mr Stabb, through to paragraph 146.

A. From the professional perspective of a registered nurse I make the following observation: The principal flaw in the system was the inordinate amount of power afforded and entrusted to the psychiatrist, the total lack of accountability and absence of monitoring or supervision of his practice and the total willingness to hand over such responsibility for the residents to Dr Leeks, by both parents and the State.

In addition, I believe that the professional conduct of some individual staff members was highly questionable, particularly those that were registered nurses in that period 72 to 74.

I also wonder about the role of the Medical Council during the Lake Alice tenure. In my opinion, they seemed very protective of Leeks post the closure of the unit, even of the Aversion Therapy aspects. Similarly the Nursing Council never made comment or raised concerns with Lake Alice. What I mean by this is that these are the groups that oversee the registration of their members. I believe they were not - they were at fault of not appropriately dealing with allegations and in particular allowing Dr Leeks to continue his practice with little control, despite concerns having been raised over a long period. The Nursing Council also could be investigated as there were clearly claims made against us as nursing staff which they ignored. They could have inquired into whether the practises of nursing staff were or weren't appropriate.

Q. Mr Stabb, we'll move now to the supplementary statement that you made in June of

this year. Most of it I believe we've covered in one way or another as we've gone through, but I know it was important to you to come back to the complaint that you helped a group of boys send off.

A. Yeah.

Q. So if I can take you to paragraph 10 of your supplementary statement.

A. Yeah. Another matter I would like to detail was that in around mid-1976 I was running sessions with a group of boys and they discussed the ECT and treatments they were receiving in the unit and they wanted to make a complaint. I remember the names of nearly all of those boys.

Q. We don't need to name them, though. So if you pick it up from "I suggested".

A. I suggested that the complaint should go to the Nursing Council and following a discussion with them they asked me to post a letter to the Nurses Council for them.

I received a sealed envelope and I smuggled it, I addressed it to the Nursing Council and I smuggled it out of Lake Alice, posting it, put a stamp on it. Nothing was ever heard back from the Nursing Council so far as I know.

I posted it outside of Lake Alice because I was worried that I could have been fired and be subject to serious disciplinary proceedings or perhaps even prison if anyone had found out about what I had done.

Q. Does that refer back to the application of the Official Secrets Act?

A. Yeah.

Q. Which you mentioned earlier?

A. Yeah, I understood that I had no avenue of addressing these complaints or, you know, if I did I would be in breach of the Official Secrets Act. I was really worried about it for a long time.

Q. And I just have one final question for you, Mr Stabb, and I should have covered it earlier, but you mentioned that after that particular incident involving - that you described in some detail, you were moved out of the unit and to another part of the hospital.

A. Yeah, to the maximum security unit, yeah.

Q. How long did you continue to work at Lake Alice after that period?

A. I worked for about nine months in maximum security unit and then I resigned and left.

Q. And would that have been - you've told us about your time from 1974 to 1976.

A. Yeah.

Q. Would you have moved to the maximum security unit within that time or at 1976?

A. The end of 76 to probably end of 77 I would have been in the maximum secure unit and

then I took another job in Rotorua.

Q. Thank you. I have no further questions for you Mr Stabb, please remain there for any questions the Commissioners may have.

A. I just have one thing that's nagging at me that I'd like to say. Lake Alice was a community in itself. Most people knew what was going on there. Nobody said anything and I often wonder why nobody said anything. When it comes to looking at what's coming out of this Inquiry and looking at the systems that should have actually prevented that, they failed, the systems failed. I can't help but remember Lake Alice as a little backwater place. Wellington was a two hour drive away. Anybody could have, from Nursing Council or from Medical Council, could have driven to Lake Alice and spent a day or even an afternoon in the adolescent unit and would have known what had gone on. Why was there no District Inspector as such, and in the future wouldn't they be wise to actually have that kind of monitoring of acute units like this? **[Shrugs]**.

Q. Thank you, Mr Stabb. I'll leave you in the Commissioners' hands if they have any questions.

CHAIR: Thank you. I'll just ask my colleagues.

COMMISSIONER ALOFIVAE: Good afternoon Mr Stabb, just a few questions if I may. Can I just pick up on that point you've just made. You said most people knew what was going on there.

A. Yeah.

Q. Could you just clarify for me please who you thought most people were?

A. Well, the hospital didn't just consist of nurses, there were cleaners, there were cooks, there were gardeners, and there was a lot - there was a big settlement of houses inside the hospital where the staff lived. There was a lot of interaction between the staff and it was - there were many people that knew what went on in the adolescent unit, I believe. But it didn't happen that anyone did anything. No-one tried to stop it. I wonder about the fact that I was fearful of the Official Secrets Act, whether that would have influenced how I behaved.

Q. Thank you, you said you were an immigrant coming across to New Zealand.

A. Yeah.

Q. Could I ask, how old were you at that point?

A. I was 25.

Q. So a young person, did you have a family?

A. I had a little baby in my arms, yeah.

Q. You said there were nine families that migrated across to work in the unit.

A. Yeah.

Q. But seven returned.

A. Within a couple of years, yeah.

Q. Only if you can recall, having discussions with them as to why they were leaving, were they not happy?

A. It was usually the wives who got homesick. And I think maybe the hospital too, disillusioned some people.

Q. About what was happening in -

A. I remember the advertising for the positions, described a modern, progressive 400 bed hospital in the Manawatu, and it wasn't a modern progressive hospital, it was a nightmare.

Q. Okay, thank you for that. And can I just refer you, in paragraph 19 you refer to a resident being tied up in a laundry bag.

A. Yeah.

Q. Was that a regular practice that you were aware of?

A. Actually don't know. I mean I - I was relieving at that time when that happened and I don't - it was literally a week or so after I'd arrived in the country, and I couldn't believe it that this was happening, that this was going on and the response, the only response I can come up with when I was told that it was part of his treatment was to just keep letting him out, which I did whenever it happened.

Q. Thank you. I just had one other question, thank you. Mr Stabb, we've heard some evidence last week about, and the use of the word cages, the use of the word cages.

A. Cages?

Q. Cages.

A. Uh-huh.

Q. So we've - it's been described to us that there were some cages outside a unit where patients or residences would be walking across probably like a compound, probably a space no bigger than about a two bedroom room it was described to us.

A. Yeah.

Q. And it had wiring around it, a bit like where you'd - the spaces - an exercise yard. Do you recall that?

A. I can't imagine what that would be unless it was the maximum security unit where there were caged areas, if you like, for exercise, but there was nothing like that in the open side of the hospital. The same thing as there was - there wasn't such a thing as a padded cell and

I've heard of people being put in padded cells, there wasn't a padded cell at Lake Alice.

Q. So the caged area that you've just referred to then in maximum, are you able to describe that for us and what that was for?

A. Yeah, it was an area off the quadrangle sort of concept of the maximum security unit(?) where really disturbed patients who couldn't be mixed or integrated with the community of the unit would be allowed to exercise during the day and they would spend hours in there, and it did - it was like a cage, yeah. But it wasn't small, it was like a mini courtyard, yeah.

Q. So just in respect of this room, are you able to give us an indication when you refer to a mini courtyard?

A. Probably this end of the room using that there as a wall. Maybe a bit narrower, yeah, a bit narrower.

Q. Thank you. And there was another reference to cages that we've also heard in evidence last week and it was in respect to like small little - actually the phrase that was used was dog kennels and there was about six of them lined up next to each other wire meshing, and they were very tiny spaces. Do you recall seeing that or would you have heard something?

A. No, what's going through my mind now, to be quite honest, is Peter Ellis and the Peter Ellis story where he talks - the complainants are taught about dungeon things. There was nothing like that at Lake Alice, I wonder whether these - it's a manifestation of what -

Q. Thank you.

A. Yeah, sorry, I can't answer that any better.

Q. Just to the best of your recall, thank you very much.

CHAIR: Just one more question from me. Quite a number of - first of all, can you tell me at that stage to your memory how many of the patients in the child and adolescent unit were Māori or Pacific?

A. I would say about 70 to 80%, there was an inordinate amount.

Q. A disproportionate number of children?

A. I might add that when I talked about this proportion of kids, the amount of children from Marton, Marton was a town of I think about 3,500, 4,000 people, and there was a hell of a lot of people, of kids stuck in Lake Alice from that little township. I don't know what that's about.

Q. So 70 to 80% were Māori or -

A. I'd say so.

Q. Yes, okay. And what proportion of the staff in the, well, you've already described how you came from the UK, as did some of your colleagues, about seven of them.

A. Yeah.

Q. When you arrived, were you given any orientation in relation to Māori culture or the way to handle Māori children or anything to do with -

A. Nothing in 1974, no.

Q. Not in 1974?

A. No.

Q. And beyond that, you were there until about 1977?

A. Yeah, there was nothing like - the days of being culturally orientated came much later, certainly not in those eras. It really was a case of here's your key, here's your uniform, get on with it, you know, that was your orientation. The reason I have such clear memories about this is that I would write a lot and I have a website that I write about Lake Alice and, yeah, I would advise anybody to have a read because you will see - you'd find the answer to your question there on the website.

Q. Thank you very much for that. I'll hand you now to my colleague, Commissioner Gibson.

COMMISSIONER GIBSON: Thanks Mr Stabb. A question in relation to paragraph 149 where you talked about the Nursing Council, GRO-C GRO-C Is there anything -

A. I think that's been redacted out.

Q. My apologies.

A. I'm rather glad you said it.

Q. My apologies. I'll check on that. I question, through the nursing process, through the registration process, is there a clear delineation of what constitutes punishment and what constitutes therapy, do you learn that?

A. I would expect a registered nurse to be fully cognisant of the differences between punishment and therapy, yes.

Q. And how would you define the difference, or how would - in any hypothetical situation?

A. The punishment side of the numbers show that punishment was very little effect, whereas therapy is goal-orientated and has been measured so that, you know, it's credible. Punishment is more a reaction by the person in charge, I think to make them feel better, and be in control. Therapy's not about that, yeah. But I take your point in terms of I find it difficult to differentiate between how can a teenager not see a needle in the backside as punishment, whether it was today or in 1974. Your average teenager would see a needle in the bum as being a punishment. Yeah, that's all I can say to that really. And especially in

this situation, Lake Alice, where you did have that culture for two years where there really was - it was used as punishment, for smoking or what have you. How do you break that? I don't know.

Q. Thanks Mr Stabb, I think it's now up to me to formally thank you for the time you've put in and coming here today, recognise it's not easy, it's been a long, long time, it takes a lot of effort to remember and coming today, so we appreciate the effort you've put in, thanks.

CHAIR: Thank you very much. And thank you again, Nick, for being a supporter. I think we'll take a 5 minute break.

MS FINLAYSON-DAVIS: Certainly.

CHAIR: Just to get our next witness ready.

MS FINLAYSON-DAVIS: Certainly.

CHAIR: We'll be back in 5 minutes.

Adjournment from 12.36 pm to 12.44 pm

MR MOLLOY: Good afternoon, ma'am, the next witness Grant Cameron. Mr Cameron has provided a substantial statement. He understands that we're under some time restraints, so he doesn't propose to read the whole thing. We're also running a little behind but I think we can probably make up the time reasonably comfortable. We might go to 1 and ask that you come back a little early from lunch, perhaps 2.

CHAIR: Yes, we've discussed that.

MR MOLLOY: We may be able to push out the last witness as well.

GRANT ASHLEY CAMERON

CHAIR: Thank you. Thank you Mr Molloy. Good morning Mr Cameron.

A. Good morning.

Q. Thank you for coming. Could I just ask you to take the affirmation. Do you solemnly, sincerely, truly declare and affirm that the evidence you give today will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you very much.

QUESTIONING BY MR MOLLOY: Mr Cameron, good afternoon. We've got a very large statement in front of us, I understand it's not the complete evidence that you're going to be able to provide to the case study, but it's the evidence you've been able to provide in the timeframe available for this hearing.

A. Yes.

Q. To this time. So we appreciate that. I'm going to hand it over to you and let you take it up.

A. Thank you. Ma'am, the problem of providing this brief starts with over 30 boxes of files which I had decided to keep because I thought one day there might be a Commission of Inquiry. But so consequently we have all the relevant information. I've been through and this, sort of half of the brief, is approaching 140 pages. I think the second brief has even more concerning information in it, we won't be able to deal with that today, but I would like to say a few words just at the end of this touching on those matters.

CHAIR: Yes, thank you.

A. I'll deal with the preliminary matters in the usual way, but there will be portions of the brief that I will not go into and I'll flag those, but I will highlight the important points as I see them.

Q. Just to reassure you that we have read your briefs of evidence, and if not the 30 boxes, and we're very grateful for that. Thank you. Just one last thing, we have a stenographer and we have two signers who require that you measure your speed thank you.

A. Yes, okay. My name is Grant Ashley Cameron and I'm the principal of GCA lawyers, a national class action practice based in Christchurch. Between 1996 and 2006 my firm, GCA, represented a large number of claimants who brought actions against the Crown in relation to events which occurred in the Child and Adolescent Unit on the Lake Alice Psychiatric Hospital grounds during the 1970s.

The groups of claimants whom I presented consisted of individuals residing at the unit between 1972 and 1978 who were 16 years of age or younger. They alleged they'd suffered abuse in various forms while at the unit.

Now the action formed two parts. Part one took place between mid-1996 and November 2001 and part 2, which was dealing with the second process that the Prime Minister arranged for potential claimants and the Paul Zentveld litigation occurred between November 2001 and November 2006.

I was asked by the Commission to provide witness statements setting out my involvement both in the litigation and the events leading up to the settlement of my clients' claims. As I say, there are two witness statements, part 1 dealing with the settlement of my first batch of claimants, the part 2 being the second and independent determination process following Prime Minister Helen Clark announcing such a process.

In this first statement I deal with background of the matter generally, how I initially became involved, the initial strategy, involvement with the media, how prospective clients were vetted, my efforts to secure funding and the fee arrangement between my firm and its clients, the initial facts presented to us, details of when and why

proceedings became necessary, the settlement process which followed and the involvement of Sir Rodney Gallen, the matter of the Law Society fee complaint and the outcome of the same, and details of the complaints made to the Police and to the Medical Practitioner Board of Victoria. As I said before my second statement deals with the Zentveld proceedings and the part 2 claimants.

I provided to the Royal Commission, in consequence of a notice received, documents and files. We complied with that notice on 25 September 2020, along with statutory declaration. I prepared this brief with regard to my confidentiality obligations in respect of my former client's interests, and the protection of solicitor/client and litigation privilege, and the confidential nature of the resolution process itself.

For these reasons, where appropriate I have elected to protect the identity of certain individuals and so refer to such persons numerically or by some other label. I have independently supplied the Royal Commission with a schedule to identify those persons. The numerical order in which clients are referred to in my statement do not reflect the order in which they became my clients.

I now turn to the background. Lake Alice, as you know, was a psychiatric hospital located near Whanganui, housed persons committed under the relevant mental health legislation at the time, including individuals referred to as criminally insane. It was a medical institution focused on psychiatric care for those in need of the same.

But in the early 1970s, the Department of Social Welfare had responsibility for many State wards. They faced housing difficulties and apparently when the Department discovered there were some empty dormitories on the ground of Lake Alice Hospital, a decision was made to use these facilities and start a special unit to cater for these children.

The unit was created during 1972 and was situated on those grounds, as I've said, children between ages of 8 and 16, occasionally there was one or two older than that. Our inquiries revealed that nobody had been formally committed for treatment under the mental health legislation of the time.

Dr Leeks was a psychiatrist based in Palmerston North and was nationally recognised as specialising in the care of children and adolescents and was given overall responsibility for management of the unit.

During my firm's preliminary investigations, we found that the unit had no legal or functional link with the operations of the Lake Alice Psychiatric Hospital itself. This was confirmed in the report of the Commission of Inquiry into the case of the Niuean boy in March 1977, where it was found Dr Pugmire, the medical superintendent of Lake Alice

Hospital, told the Commission he has a written direction not to involve himself in clinical matters in the psychiatric unit.

QUESTIONING BY MR MOLLOY CONTINUED: Can I just ask you to pause there, Mr Cameron, do you know who was that from?

A. That was from the Commissioner who carried out that inquiry.

Q. Sorry, but do you know who the written direction was from?

A. No, I don't. The position, as it appeared to me, then was that we had Department of Social Welfare looking after State wards, and simply needed somewhere to house them, feed them, educate them, but in those circumstances, and given the artificial legal severance of the dormitories from the asylum itself, there was no need for an ECT machine, nor for Paraldehyde or other drugs to be administered to such State wards. So that was the position that we started from.

By 1976 allegations of abuse came to light. Report that Dr Leeks and nurses at Lake Alice were administering ECT and injections of Paraldehyde as a form of punishment. There were further allegations of physical, sexual and unlawful - sorry, abuse and unlawful confinement.

These allegations were raised by Jonathan Hunt in Parliament in 1976 and I understand that the Ministers of Health and Social Welfare at the time denied that medical procedures were being used as a form of punishment and resisted calls for an inquiry.

On 27 January 1977 Judge Mitchell was appointed to hold a Commission of Inquiry into the care of one young person. That concluded on 18 March 1977. The scope of the inquiry was limited to only the treatment of that one young boy. Judge Mitchell stated in his report "I am certain that ECT was not used as Lake Alice Hospital as a punishment." That young boy later became a client of my firm whom I shall refer to in this instance as client 1.

In January 1977 the Ombudsman received a separate complaint from another individual's parents. This investigation was also limited in scope to the complaints made by that one individual. There had been some consultation with experts following which Sir Guy Powles issued the following, it was stated "there is a general consensus of opinion and the general practice is that ECT plays little or no part in the treatment of children. In most circumstances it cannot be justified." He recommended that "the Department of Health ensure that the medical superintendent of Lake Alice Hospital has closer control over and final responsibility for the administration and operation of the unit."

As a result of further complaints, calls to parliament for a full Commission of

Inquiry continued through 1977. The Minister of the time, Hugh Templeton, maintained an inquiry was not needed.

A Police inquiry was conducted in January 1978 but nothing seemed to result. The unit ceased operating and was closed in 1978 and Dr Leeks was dismissed in July of that year. He took up residence in Victoria.

Q. Again, can I just ask you to pause there. When you say he was dismissed, what makes you say that?

A. I am sure one of my solicitors has found a piece of paper indicating that, but I don't recall what it is. I can't confirm.

Q. Thank you.

A. In 2006 whilst the Medical Practitioners Board of Victoria was in process of investigating complaints, he surrendered his Australian medical licence and thus ended the board's investigation.

In 2017 a former client of my firm, Paul Zentveld, made a complaint to the United Nations Committee Against Torture and his complaint was upheld in 2019.

How I came to be involved. In September 1996 I received a telephone call from a lawyer at a Blenheim law firm. He had a client who had been in Lake Alice in 1972 at the age of 13 years. He was a ward of the State. There were obvious limitation problems in trying to commence a civil action but the lawyer asked if I might accept a referral and deal with their client directly to see if something could be done. Although the client lived in Marlborough, he regularly attended a pain clinic at Burwood Hospital in Christchurch so it was agreed that I would meet him in my offices when he next came to Christchurch. I shall refer to him as client 3.

When we met he described his signature physical symptoms, including severe muscle cramps and spasms, he believed this was as a result of the long-lasting effects of ECT and/or Paraldehyde injections he'd received while at Lake Alice Hospital in the 1970s. He informed me that his specialist supported that view and that his problems were probably attributable to those experiences. He wanted advice regarding compensatory options. I agreed to consider whether I could assist him and suggest the that we meet a fortnight later

Within a week of that meeting, I received a telephone call from a lawyer based in Wellington, lawyer A. He said that he was calling me because he was aware of my experience in dealing with group or class actions and wanted to know if I could assist with an issue affecting one of his clients, that I refer to as client 4.

Lawyer A's client had been a State ward at Lake Alice during the early 1970s. Lawyer A's client's experiences was very similar to those of the client referred to me from Blenheim. Given these similarities, lawyer A and I became concerned there may be many other former Lake Alice residents who might have been similarly treated and affected.

Lawyer A was a sole practitioner specialising in other areas of law and he wanted to know if we could cooperate with a view to jointly investigating the facts, exploring possible remedial options. We quickly reached an agreement on maintaining a joint approach to the issues.

We commenced a general investigation, engaged a private investigator to locate some of the former residents, many of those who we did locate had almost identical complaints.

There was another individual represented by an Auckland law firm had already filed proceedings against Dr Leeks and the Attorney-General and those allegations were very similar as well.

This soon led to discussions with counsel and we opened a dialogue with David Clarke, solicitor at the Ministry of Health, on or about 29 February 1997. Early in 1997, lawyer A and I discussed media options because we felt that raising awareness among the pool of former unit residents who had been similarly treated and affected would be beneficial. Lawyer A spoke on the Kim Hill show about that time. I contacted TVNZ, TV3, the Dominion Post newspaper did an in-depth article about Lake Alice tracing events through the 1977 Commission of Inquiry.

So by June 1997 we had approached - we had been approached by a total of 32 individuals. They were all kept separate, they all wished to speak about their experiences. It was clear to me the great majority of those coming forward had no opportunity to confer with others before doing so. In those circumstances the consistency between their respective stories was striking.

We were then approached by the producers of the 20/20 current affairs programme advising they were interested in running a documentary. They wanted to locate some of our clients and see if they would cooperate. In June 1997 lawyer A informed me he was going to close his practice and take up an in-house corporate position. It was agreed I continue with the full conduct of the case from the point he took up his new position.

We suggested at this stage - sorry, on 3 July 1997 we wrote formally to the Attorney-General laying out the background. We suggested at this stage the matter of compensation should be put to one side and suggested that a further inquiry should be

commissioned. On 6 July 1997 20/20 presented a 40 minute television expose of the events of the unit focusing on the experiences of four people. Those were clients 5, 6, 7 and one anonymous.

The programme caused wide media commentary. On 7 July 1997 Bill English spoke on the Kim Hill show and I will quote what he said. "I was horrified, like everyone else, these people were about my age, so when I was getting on the school bus and having a healthy, secure childhood, these people were being terrorised and I found it very moving. I have no reason to disbelieve them. There was a much higher level of acceptance that whatever was going on in these places was acceptable, what was going on there was invisible, the issue of recompense is a whole issue of liabilities. My instinctive reaction is that the State ought to recognise that things happened and not sort of hide behind a whole lot of legalisms, although in the end we all have to deal with the legal issues.

In my capacity as Minister of Health and as an agent of the State, I suppose we have to recognise that these were State-run institutions, that if these things happened in a domestic environment they would certainly be litigated, you'd find a feature of this in other places like it, there is no accountability.

What I'm in a position to make some judgment about, whether or not the State exercised its responsibility to treat its citizens with dignity and respect, and my guess here, my view here is that it didn't and I think it often failed to do it in a number of these institutions."

Q. Just pause there at the then Minister's very human reaction to what he'd heard. I'm just looking at the time and I'm wondering if there's a convenient moment in the narrative where up might pause very shortly.

A. I'm sure we can. There's a subject heading on how I vetted my prospective clients about a page away, so I think we should do it there. So I heard nothing back from the Ministry of Health in response to correspondence of 3 July 1997 so I wrote to Bill English on 21 July 1997. I considered it appropriate that we meet with him and he replied on 29 July stating:

"The issues raised in your letter and in the material I have received from lawyer A are serious and I agree that consideration needs to be given to the most appropriate way in which to address these matters. I am presently considering a range of options and invite you and lawyer A to have a confidential, without prejudice discussion with me before deciding on an appropriate course of action. A member of my staff will be in touch within the next few days."

There was then a meeting with Bill English and over the course of the next few

months we made several approaches to the Ministry of Health by telephone and correspondence which provided them a comprehensive picture as to the nature and scope of our clients' allegations with suggestions as to how the matter might be practically resolved, and in summary we suggested that an inquiry should take place. We considered a non-court resolution process was appropriate.

More individuals continued to approach us and by August 1997 we had spoken with approximately 80 former residents of Lake Alice. By mid-September 1997 lawyer A's involvement ended and my firm maintained the case thereafter. At that point perhaps we could take the break.

CHAIR: All right, thank you for that. We will take a break, we'll come back a couple of minutes after 2. Thank you.

Lunch adjournment from 1.05 pm to 2.03 pm

CHAIR: Welcome back, Mr Cameron, and thank you Mr Molloy. Just keeping an eye on speed please if you can. I know it's hard.

A. I have no trouble going slow.

MR MOLLOY: Just before you do, ma'am, there is just the one matter.

CHAIR: Oh I forgot. The embargo that I made before about the evidence of Mr Brian Stabb has now been lifted and the press are free to report as they see fit.

QUESTIONING BY MR MOLLOY CONTINUED: Thank you ma'am. Mr Cameron, before the break you covered something of how you became involved in this matter, and approaches made to the Ministry of Health and the Minister. It might be useful to cover off a few matters now such as I think there have been suggestions from time to time of people jumping on band wagons; be useful to tell us how you addressed that and then perhaps go through how the matter was to be funded and what arrangements you reached.

A. Certainly. From the outset I perceived there was a risk of persons who had perhaps never actually resided at Lake Alice potentially coming forward to join a prospective class action in the hope they might receive some fiscal recovery. Therefore we developed a form of filter that ensured early detection of any false claims. As the unit had closed in 1977 we reasonably expected former residents would have had little or no contact with each other, and so going forward, these prospective clients or new clients would only have contact with me or my staff and we were at pains to ensure that they had no ability to contact others or to cross communicate.

We took - everybody was subjected to full interviews in accordance with the template that we'd developed. Nobody got any forewarning as to questions they would be

asked, and basically we looked at not just legal issues and their experiences, but developed a series of questions that were interspersed which were regarding facts unique to the unit. I've set out those in paragraph 49, a couple of examples being where were the physical locations of bathrooms, toilet blocks, classrooms, what was the colour of the toilet door on a given dormitory, full description of Dr Leeks, the car that he drove, the colour, what damage it had etc.

By having those matters that only a resident would know about we were able to quickly determine who was presenting false claims. In the final analysis, only one individual ever really did attempt that, and I think the fact that people just simply weren't in contact with one another and we were able to keep them apart ensured we were happy that all the complaints received were genuine.

I turn to how the litigation was funded. From the outset it's plain that the vast majority were not in a financial position to fund legal costs in basically any meaningful manner at all. It was highly unlikely any Legal Aid Committee would advance funding and I certainly wouldn't contemplate dealing with a Legal Aid Committee on such a case. In my experience the ultimate form of resolution would have to be with a political agreement with the Government and I certainly couldn't have managed it on a Legal Aid basis.

Therefore there was no alternative, in the circumstances as they pertained at that time, other than for me to underwrite the action myself. In turn that meant that a quasi-contingency fee arrangement had to be established and this was necessary because in 1996 there was no effective litigation funding options, access to justice was entirely dependent on plaintiffs making their own financial arrangements for legal services.

I anticipated the Crown may agree to some form of independent inquiry after it was fairly presented with all the relevant facts. If the parties then cooperated, the Crown might fund our reasonable costs at least during a fact-finding phase. And so I sought - I decided to seek a Crown contribution to costs.

Now this is against the background of the fact that I'd acted for the families who were affected by the collapse of the Cave Creek platform and when that had occurred those families had come together and approached me and instructed me to act in the matter. John McGrath, the Solicitor-General at the time, very quickly arranged for us to be funded through that process. There was a full inquiry and a normal conventional process followed, and there was no issue about costs and I had that sort of arrangement in mind at this point.

We provided the Crown with a detailed nature of the allegations and suggestions of specifically how the matter might be addressed. I made requests that the Crown

contribute to my clients' costs as early as August 1997. And by letter to the Ministry of Health on 11 August made a very detailed request for funding. In that document I detailed the anticipated work, I alerted the Ministry of the fact that the dispute resolution process I was proposing was closely modelled on the process the Crown entered into with my firm and resolving the civil claims arising from the Cave Creek case. That was a determination process that commenced after conclusion of the Commission of Inquiry.

I then elaborated on and reiterated my request for Crown funding and there were different proposals made on at least 13 occasions and I've detailed those at paragraph 60. Although I was persistent in my attempts to secure Crown funding for my clients, ultimately this was to no avail, therefore I had to prepare terms of engagement that would provide a fair solicitor/client fee arrangement and fairly offset the significant financial risks that I would personally assume in embarking on such a project. Obviously those risks included the risks of not being paid at all, the risks of not covering costs should the fee cap in the solicitor/client agreement operate to limit the firm's recovery despite actual work in progress being a much higher level than the sum contractually recoverable.

This arises because there was a fee cap. I think it described initially as 40%. The real risk here would be that perhaps we might do $1 million of work in progress and recover $200,000 and if it was a paltry sum of money that had to be split between clients then we would only be able to recover 40% of that smaller sum. So again, I guess given experience, I was not anticipating large sums of money being recovered through the civil litigation

There was a considerable risk of not recovering client contributions to the disbursements being met. And I'll come to the disbursements issue in a minute. There was a risk of total disbursements exceeding the cap, that again I had placed on disbursements so clients were protected from having an open-ended disbursement liability.

And of course the ultimate risk was the risk of being liable for adverse costs should the matter fail at trial. And who knows what that liability would have been. The litigation risk was immense, there was quite plainly limitation defence options available to the Crown. So taking all of these matters together, the risks were much higher than conventional litigation.

There were two solicitor/client agreements offered to clients. And the first was presented to clients in August 1997. It provided instructions for me to obtain a negotiated financial settlement with the Crown. So I want to emphasise the fact that it did not contemplate litigation specifically for an alternative dispute resolution mechanism, ADR,

and the only contribution clients were required to make was to pay $100 as a contribution towards anticipated costs and disbursements, which in real terms meant a contribution to disbursements.

Now all the other terms of that agreement are detailed in paragraph 65. But because that agreement was never used I won't go further into that.

In the event, no reliance was placed on the first agreement because the Crown finally rejected entering into any alternative dispute resolution process. Therefore a fresh agreement had to be presented to clients catering for the fact that litigation was now required and apparently was inevitable.

So the second solicitor/client agreement was presented to clients on 12 March 1999. It was very much in the same terms, I might add, as the first one, very minor adjustment.

Key provisions were, the early agreement was at an end, GCA was instructed to obtain a negotiated financial settlement with the Crown, or issue the matter through a litigation process, that being the key change to instructions.

Clients were to pay an additional $300 to GCA's contribution towards anticipated disbursements, not costs this was just for disbursements, and there is provision for a further contribution of $200 towards disbursements in required and if called upon.

Significantly, any disbursements incurred over and above the $500 contributed by the clients would be met by the firm and would not be deducted from any settlement monies later received. The client's obligation to pay fees was changed to "a figure not exceeding 40% of the monies recovered on the client's behalf inclusive of GST."
I emphasise the fact that it was inclusive of GST, therefore making it almost the same as the terms of the first agreement.

Note that there would be no further deductions on top of that sum in respect of disbursements. If no settlement or financial recovery was achieved, no fee would be payable by the clients over and above the contributions already made. Once again, clients were advising and encouraged to seek independent advice about the nature and significance of the agreement.

GCA carried virtually the full risk of non-payment in the event there was no financial recovery. Not only did my firm limit the monies which could be recovered from my clients for disbursements, it also committed to a self-imposed cap on the total fees chargeable so the fees could never exceed the stated percentage of the ultimate recovery. By this means all clients were guaranteed to recover a substantial proportion of any

recoveries without risk to them, regardless of how much work was ultimately completed by GCA.

This was a particularly important client protection in the event relatively low compensation was ultimately recover, and in those circumstances the firm anticipated overall losses.

QUESTIONING BY MR MOLLOY CONTINUED: Ask you to pause there. Do you know if any of your clients did take independent advice?

A. I can't be sure. Well, I'm sure that some did actually take independent advice, but I really don't have information before me as to who they were. They would certainly be in the minority though.

Fee agreements provided authority for me to enter some form of resolution process with the Crown or seek a negotiated settlement. As the case developed, the financial risk for myself and the firm grew substantially. During the course of the part 1 process I incurred significant business and personal debt, all of which was secured against my family home.

Later in the process it became necessary for me to sell a family trust asset to fund the firm's position. By the time the part 1 claimants had their claims finalised in September 2001, my firm's unrecovered work in progress was approximately 1.55 million, but this figure does not include the time spent by my staff distributing the settlement monies and dealing with a significant number of queries from both clients and the media in relation to the settlement reached.

Approximately 40 of my clients had made no - 40% sorry of my clients had made no contribution to the disbursements whatsoever. For those who were able to make contributions they often came piecemeal in relatively low instalments, perhaps $20 a week.

By October 2001 at the conclusion of part 1 my total outlay of disbursements was a little over 152,000. The solicitor/client agreement provided that in total I could not recoup more than 54,100 and therefore my firm and not my clients funded the remaining disbursements in the region of 97,500 so that was an irrecoverable sum.

Q. Just ask you to pause there. I think you were about to go through some examples of the kinds of accounts you were dealing with. I think over the course of the first week of this hearing we got a pretty good idea of many of the accounts that would have been similar, I suspect, if not the same. So I invite you just to fast-forward perhaps to the bottom of about page 30 of your brief.

A. Yeah, I was going to open this section by saying I will not go into these. I turn to

paragraph 73 and briefly note that other allegations were made, including but not limited to physical and sexual abuse such as being hit with a tennis racket, being locked in a cage alone with a deranged adult, being made to eat vomit, threats of being thrown off a balcony, abuse of disabled children, waking up from anaesthetic whilst being raped, other acts of rape and sodomy by staff and adult patients at the hospital and coercion into performing sexual acts on staff.

Q. Can I just ask you to pause there, I'm not selecting one of these for any reason other than that there were some suggestions made last week about a cage. I think Commissioner Alofivae asked the first witness this morning about that as well. Do you remember anything about the cage allegation?

A. Yes, there is a client who I haven't referred to in this brief at all, but who did describe as a punishment the fact that staff would take an individual child across to the main asylum where there was reputedly a severely mentally disabled adult kept in a cage. And the punishment was to put the child in the cage with this adult. And of course it was hard to imagine anything more horrific, child or not, and if you were to be left there or knew that you were to be left there overnight, and this adult played with you as if a toy, it was a truly appalling sort of situation. So we do have statements which touch on that. I can't give you more details at the moment.

Q. You don't recall where the cage might have been other than it was at the adult unit?

A. My understanding was that it was part of the main hospital.

Q. Thank you, I'm sorry, please pick up.

A. Following the first batch of client interviews it was clear that we were facing a very serious issue, because all complainants were children when resident at the unit, all came from difficult family circumstances, all could be said to be vulnerable persons.

State and its agencies were in an fiduciary relationship with these persons. All complained of serious breaches of duty, to the best of our knowledge none had been committed to Lake Alice under the Mental Health Act legislation. There was virtually no opportunity for complainants to conspire or develop false accusations. As a matter of commonsense, there was virtually no possibility of individuals presenting near identical stories in isolation from each other more than 20 years after the relevant events.

All complained that the primary abuses were intentionally applied as punishments for minor infractions. There was no apparent medical reason for their caregivers to act as they did. In the absence of a genuine medical reason for the application of ECT or Paraldehyde. There were significant risks that clients had suffered the deliberate

application of child torture.

Prior to media commentary, all complainants responded to my firm's inquiries with remarkably similar statements and their stories were shocking and often horrific. But all displayed extensive and genuine emotion about their experiences and despite educational and other personal limitations, their stories were relayed in a compelling and credible manner.

At that point the overall picture strongly suggested good cause to suspect the commission of crimes and very serious breaches of fiduciary duty. So it was against that background that my firm had to develop a strategy to try and address the issue.

Q. I think you're about to go on in your statement into the consideration you gave to filing Police complaints at that stage.

A. Yes.

Q. I might invite you to come back to that later in the day when you did actually lodge those complaints.

A. Yes, that's fine.

Q. That said, what was it that your people did want and how did you go about achieving that?

A. In preparing a strategy for any, shall we say, larger project, class actions in particular, you must take into account the clients' instructions, their needs, their objectives, and the particular circumstances that you were faced with. I found from prior experience that cases involving disaster, serious trauma, client objectives actually fall into fundamentally four categories.

The very first one is prevention. For the majority of clients, this was their dominant motivation. They never believed they would be listened to or that institutions would take any effective action in relation to their complaints. However, if there was an opportunity for some public awareness whereby effective changes might be made, then this was often said, "nobody else would have to go what I went through."

The second issue is apology. Clients feel the hurt and distress from their personal experience and they look to the wrongdoer to now accept their errors and step forward and make a genuine apology. Often this goes a long way to diffusing what is otherwise a very difficult situation. But in this case, as with others I might add, there seems to be an ingrained institutional attitude that making any form of apology would be construed as an admission of wrongdoing, and that therefore it would complicate efforts to defend claims. I disagree with that sentiment, but that was the reality we faced here.

Punishment. Clients generally look to wrongdoers being answerable to law.

I stress the fact that they are not looking for vengeance, they're simply expecting the law to be applied in an even-handed manner. Therefore, even if wrongdoers might be public servants, clients expect the law to be applied just as it would for any other citizen.

If it is applied in that manner, clients largely remain bystanders. However, if it is not fairly applied, or if there is a hint of special treatment or cover-up, this rapidly becomes a major issue for clients.

Finally, compensation. It's only after the first three objectives have been addressed that clients tend to consider their own position. In pursuing compensation, clients often perceive this as a way of causing wrongdoers to tangibly address their wrongs. A payment tends to reinforce the genuineness of any apology. It operates as a small element of punishment. It may serve to ensure that institutions move to adopt best practices for the future.

So in the client's mind the compensatory or ex-gratia payment can reinforce the possibility that genuine reform and future preventative mechanisms will emerge. However, in a case like this no monetary award can ever compensate for the suffering actually experienced. That's often accepted by clients, but after some explanation, I might add, and focus remains on the need for a payment and far less on the question of quantum.

Q. I think at that point you explain what you're looking to do really is to achieve a result without having to go down the litigation route?

A. Exactly.

Q. You're looking to promote some kind of alternative dispute resolution process?

A. That's right.

Q. And you're looking to use the media and, where necessary, direct lobbying to pursue those aims?

A. That's right.

Q. So from about 1996 through until eventual resolution those were the strategies you adopted?

A. Precisely. It is a three-pronged approach. I think you need to explore the opportunity for the parties to sit down, talk through their differences and come to a meeting of the minds. Legal proceedings should always be a matter of last resort. Time costs, hassle, litigation risk for plaintiffs all provide great uncertainty and great difficulty. Deep pocketed defendants can always indulge in delay, deny, defend strategies designed to run you out of time and money until you just give up and go away.

So using the legal processes such as they might be, engaging with the media to

actually encourage public awareness and discussion, and in some cases direct lobbying so that the true client on the other side, which in this case is Government, has been receiving the right messages, not the messages that have been filtered through officials.

Q. So does this bring us back to the 20/20 documentary that you referred to before and engagement with the Minister at the time?

A. Yes, it does.

Q. I think you pick that up at about page 41.

A. Yes, that's right. So in terms of the large number of people we had coming forward, we had to obtain the facts and get accurate pictures from them, as to what had taken place. We discussed with a QC what course of action might potentially arise and that was continuing discussion. We need to determine whether the application of ECT or Paraldehyde could be validly viewed as some form of expert medical treatment. And so it was necessary to engage and obtain some sort of expert advice.

We made some preliminary inquiries and found that a New Zealander, Dr Steven Baldwin, a psychologist and professor at Teeside University in the UK, was internationally recognised as an expert on the misuse of ECT. I emphasise "misuse".

So he was immediately intrigued by the Lake Alice case and he quickly informed me that ECT should never be administered to children and there were no circumstances in which that should be the case.

As regards Dr Leeks explanation that the Commission of inquiry held in 1977, that he had administered ECT to the boy concerned because he suffered from epilepsy, Dr Baldwin was quite adamant that ECT was never a treatment for epilepsy.

I also spoke with Dr Ding, a clinical psychologist of national renown. My recollection is that he had recently retired at the time, but he certainly agreed with the views of Dr Baldwin.

It was after that that lawyer A and I met with Bill English at parliament on 6 August 1997 for about eight officials present, including members of the Crown Law Office, Ministry of Health, I documented the discussions which we had at this meeting in my subsequent letter to Mr English on 13 October 1997.

In the meeting we set out for Mr English the nature and scope of the information received. I was at pains to point out that substantial evidence existed, indicating that there had been systemic and intentional child torture at the unit. I record that despite the commission of inquiry, the Ombudsman report and earlier Police inquiry, no effective action had been taken.

Given the context of the recent 20/20 television programme, Mr English said he was appalled and he believed the issues raised by the case should be addressed. I then suggested consideration be given to using the same determination process which had proven very successful in resolving civil claims following the Cave Creek Commission of Inquiry.

Q. I think you then describe that process and I think you can probably flip forward to perhaps over the page.

A. That process had been run by Sir Duncan McMullin as the determinator and the process proved to be highly successful. I suggested to Bill English a dispute mechanism based on that model would be appropriate. It might best ensure attainment of our respective objectives, and it would be a fair reasonable and independent outcome.

And he agreed that officials would explore this more fully. That was not a binding commitment, but certainly we went ahead on the basis that the Minister was genuinely looking for a suitable resolution mechanism that would not require protracted court proceedings.

Therefore at that point we had the impression Crown was co-operating, it seemed self-evident that if there was any possibility of children being tortured at the unit, the State needed to make urgent and extensive inquiries to establish the facts.

At the same time as we were having these discussions, the Crown was attempting to strike out the McInroe v Leeks proceedings. Of course that by 2 August 1996 Master Thompson declined to strike out those claims. In August I wrote to the Ministry of Health, reiterated our proposals, and then I wrote to my clients on the 18th of that month reminding them that litigation is the final step, a matter of last resort.

I also wrote to the Ministry of Health on 25 August 1997 seeking a waiver on the limitation issue. My intention being to establish some certainty for my clients and to determine Crown intentions on this point.

That recorded that I'd had a preliminary discussion with Robert Chambers QC who was counsel on the McInroe case. He had indicated that he and his clients were prepared to join in any resolution process that might be agreed between my group of clients and the Ministry.

Q. Can I just ask you there, is it fair to say that over the course of the rest of the term of that particular Government, the apparent position adopted by the Minister of Health when you first met in July 1997 gradually hardened?

A. Yes, I had to draw a distinction between what the Minister had said to me face-to-face, a

little bit of information perhaps I was receiving vicariously as to political thinking, and the communications that were coming from the Crown Law Office. But the Crown Law Office obviously was putting the official position to us and it hardened considerably.

Q. I don't want to rush you through matters that are important to you, but is there a way you can conveniently summarise those three years into a few minutes?

A. We'll do our best. Just bear with me. I think it's fair to say that during this period we had a great number of communications, they are detailed, of course, and I don't think, unless you think otherwise, we do need to go into the detail of all of this. I can look for certain examples as to the sort of tightening attitude and I could touch on one or two matters perhaps.

CHAIR: I wonder, Mr Molloy, that if you perhaps selected those in light of the fact that you'll be probably asking questions from the Crown at a later date, maybe pointing out some of those issues.

MR MOLLOY: I think it's all set out, Mr Cameron's outline of events is all set out, ma'am.

CHAIR: Okay.

QUESTIONING BY MR MOLLOY CONTINUED: I think you get to the point where at some point you decide that discussions have come to an end.

A. Yes.

Q. And you may even have been told but you certainly formed the view that alternative dispute resolution was no longer on the table and that litigation was going to be necessary, at least to advance matters further?

A. Certainly. I think I touch on two matters just before the final letter I received confirming that matters on ADR track were at an end. The first paragraph 138 I refer to a document which I sent the Ministry of Health, it was called "The Children of Lake Alice", and it was described as issues, this is an attachment which runs to I'm guessing 20-odd pages.

Q. I think you've exhibited that and if we can call that up, it's witness 0638002. I'm not suggesting we go through the entire document, but there's two pages of contents which probably outline -

A. That's exactly what I wanted to do.

Q. - give an impression. If you go to pages 2 and 3 of that document.

A. The point of this document was to fully confront the continued Crown suggestions or insinuations that somehow there was not reliable evidence as to these events having taken place. I thought the evidence that was systematically supplied to them was compelling and indeed overwhelming. So looking at the contents, you'll see that this document was

comprehensive. We described the history of the matter, the Minister's reaction, our meetings with the Minister and subsequent communications. We had a draft statement of claim, we had complainant statements, we met through all the specific issues set out in item 3. The evidence in totality, we described the sadistic culture, the breach of professional trust, and a complete absence of management or supervisory disciplines.

It also brought in, I think, the foreign concept at that stage, breach of fundamental human rights. It seemed little interest in that on the other side of the fence.

Resolution options, what the benefits were, and of course at the end we came to a position. I'd just like to - I would say at 6.1, the evidence is ample in the sense that 89 complainants assert very similar stories and compelling because of the completely independent nature of their complaints, and the evidence contained in volumes 1 and 2 now before the Crown constitutes a prima facie case and compels immediate action. That's all I need to refer to there.

On 28 September 1998 I sent a letter to the Ministry and that's set out as Exhibit B. Perhaps we could turn to that.

Q. Can we bring up document 2. The page after that I think.

A. It's actually after that again. That's it. No, sorry.

Q. So that's the letter from you to -

A. No, it's the next one to the Ministry of Health, sorry, this one here, yeah. So all I want to refer to is the paragraph 1. "We've considered your letter of 18 September and believe it confirms that the Ministry has not progressed this matter in any substantive matter in over 15 months." I then detail the history again and by paragraphs 2 going right through to about 15 detail the many communications that have taken place.

So then if we go to item 4 on page 4. That's it. Yeah, I then add, "Since then the Crown has thought more detailed information. It's sought a draft statement of claim, volume 1 of client statements, volume 2 of client statements, an issues paper. The Crown's position was summarised as follows."

And then I turn to our position in consequence of all of that information that had been in place before the Crown. And at item 7 on the next page, thank you.

"We will now revert to conventional paths and all assurances as to containment and otherwise are withdrawn. Constant media requests for information have been turned away, however in light of your(?) letter of the 18th, the Crown's attention to this matter is now the focus of a further television inquiry and further steps are being taken."

And the final paragraph: "Despite the palpable lack of action at Ministry level he

remains accountable for the same - I'm talking about the Minister - and it seems probable that third party scrutiny will conclude that Crown's path has been quite calculated and deliberate. Perception of such and intentional strategy on the Crown's part must surely appear extraordinary to the independent viewer when the true scope and magnitude of these events are taken on board. If the Crown responds in this fashion to systematic and large scale child torture, what value is there in this Government being a signatory to various conventions of human rights and children's rights in particular."

So we said that we would proceed to court. Now the Crown did respond by indicating that I had somehow misinterpreted their letters. I think if we skip on through my brief here, we had a meeting with the Crown, took John Billington QC on 1 December 1998.

Q. Paragraph 155.

A. Yes. And we achieved nothing by way of progress in terms of trying to get an ADR process. There was then considerable effort and debate about getting the Crown's promised letter - sorry, paper to Cabinet on a possible ADR process. Whilst I received endless suggestions of Crown genuine commitment to a fair and timely process for resolving the significant Lake Alice issues that we had raised, he was not hopeful of getting the matter addressed before Christmas, and I had made that largely the final deadline.

On paragraph 170 the Crown Law gave us a letter on 17 December explaining officials were exploring the impossibility of an inquiry by the Ombudsman who were making efforts to have the matter referred to Cabinet as promised. But in order to obtain approval to pursue any form of ADR process, the Crown required considerably more information about the nature and extent of the potential claims against it.

This is despite the truckloads of evidence that had been given. I think the letter provides some insights into Crown thinking where at paragraph 3 of that letter it stated, this is the Crown stating this, "There is a considerable difference both in practical and political terms between requesting Cabinet authority to set up an inquisitorial process and requesting authority from embarking upon a process which will be aimed at both fact-finding and finally resolving the matters in dispute between the parties." This was semantics gone mad, in my view.

Q. There's then further months of correspondence being exchanged.

A. Yes.

Q. And when in fact were proceedings, first set of proceedings filed?

A. Well, I think if we look at paragraph 187 it was on 2 March that we received a letter - 1999

we received a letter from Crown Law saying that after consultation the Government does not consider it would be appropriate to sign an alternative dispute resolution process, and that was taken as the final flag for litigation to formally commence. So if I turn to the proceedings.

CHAIR: Can I just point out at this point, just for my satisfaction and knowledge of everybody else, you are now at March 1999.

A. Yes.

Q. When had you started?

A. Sometime in 1996.

Q. Yes, so we're a long way down the line.

A. The magic word is perseverance.

Q. Indeed.

QUESTIONING BY MR MOLLOY CONTINUED: I think at 195 you talk about when the proceedings were filed.

A. Sorry.

Q. 195.

A. Yeah. So the proceedings were filed in the High Court at Wellington on 21 April 1999. There were in fact two statements of claim. The first one related to 56 plaintiffs and I think that was the one relating to persons who had been at the unit prior to the ACC regime coming into force. And the second related to the other 32 who had been there after the ACC regime came into force.

The proceedings themselves were not actually representative actions, but were multi-plaintiff statements of claim.

Q. Was there a reason for that?

A. Yes, there was. There was considerable doubt in the 1990s as to how the rule as to representative actions might be applied and we anticipated we would be probably on a trip through the Court of Appeal and Supreme Court on those issues, and it simply wasn't required to be framed in this way and it also took away the adverse cost risks for the representative. In both cases the defendant was the Attorney-General on behalf of the Ministry of Health.

Q. Can I just ask you there, did you give any thought to joining the Ministry of Social Development?

A. I can't recall specifically, I think that was a matter that counsel looked at, but I don't recall the detail.

Q. Thank you.

A. Causes of action are set out at 198 onwards and, again, I don't propose going through those or the allegations specifically made, other than to say at paragraph 201 that the specific course of action would breach a fiduciary duty, unlawful confinement and false imprisonment, assault and battery and negligence.

I've been asked to comment on Crown defences, but to the best of my knowledge the Crown never filed a statement of defence. Instead, on 28 April the Crown Law Office wrote to us saying it required further particularisation before they could file a defence. We wrote to them by reply and said that it was for the defendant to elect whether to raise the Limitation Act issues by way of an affirmative defence.

They persisted in saying they couldn't file a defence without having further particularisation. They drafted an application seeking an order for the statement of claim needed to be further particularised but it was never filed. They then sent us two documents, one was 144 pages and another was 84 pages, detailing what they required by way of particularisation.

Shortly thereafter parties resumed discussions about the possibility of issuing a small number of test cases and discussions actually reverted to possible alternative dispute resolution processes.

I don't know whether it would help going into my thoughts on Crown defences because it's a little bit speculative. There are various thoughts on particularisation have been detailed at paragraph 217 and that speaks for itself.

I go to paragraph 218 and state that during the period between the meeting with the Minister on 6 August 1997 and the Crown Law Office's final letter of 2 March 1999 stating the case had to go to court, I found the Crown Law Office's position unprincipled for two reasons. I refer first of all to the Cave Creek precedent.

When faced with potentially difficult legal claims being brought on behalf of the estate survivors and families affected by the Cave Creek disaster, the then Solicitor-General John McGrath QC was able to pose an ADR solution during the very first meeting that he had with myself and Brad Giles QC. The final agreement as the process by which those claims might be resolved was then reached within three weeks.

John McGrath did not seek particularisation of claims and/or produce a plethora of technical legal issues in respect of which he required satisfaction before agreeing to such a process. Instead, he immediately recognised the value of the determination process and that once the process had been agreed, it would itself take care of all the attendant technical

issues.

If the Solicitor-General could make such clear-cut decisions on an early and brief review of the situation and then immediately obtain the necessary consents from Cabinet, it seemed to me the Crown Law Office could have achieved the same in the face of systematic and long-standing child torture allegations, had it been minded to do so.

Again, I have no knowledge as to its precise instructions, but there was an obvious inconsistency here which the Crown Law Office never addressed or explained.

There was also illogicality in certain prerequisites, the consideration process. In this regard the Crown Law Office's correspondence made it clear that there was a range of prerequisites about which it needed to be satisfied before any consideration might be given as to the particular form of resolution process to be applied, and whether it might include resolution of compensation questions.

Essentially such matters were framed around the notion that there was first a need for a factual basis for claims to be established. But one manifestation of this thinking was the requirement for particularisation as a prerequisite to finally determining the question of the appropriate process to resolve the matter.

The difficulty with this was that the Crown was simply being asked to decide what process it would commit to. We had cited our reasons for a single stage ADR process before a determinator, but the Crown was maintaining that it needed a plethora of information before it could decide or commit.

If a court resolution process was finally agreed, then a court process would determine the facts, deal with the issues such as particularisation, and all the usual procedural and interlocutory matters.

Likewise, if a private ADR process were agreed, that process would deal with those issues in just the same way. Therefore, the simple question of which process to use did not give rise to the issues the Crown Law Office sought to maintain. This had been recognised by John McGrath QC when he proposed the determination resolution process in the Cave Creek case and certainly Sir Duncan McMullin had the ability to deal with all procedural matters once that process started.

In relation to Lake Alice claims, the private determination process would have left the determinator resolving how the matters of apparent interest to the Crown would be dealt with. If claims were found not to be fact based, or not to reach the required threshold, then the determinator would remove them from the process.

In this way, Crown Law Office suggestions about needing resolution of a range of

issues before committing to a resolution pathway was wholly inconsistent with the path its own former Solicitor-General had so effectively marked out with Cave Creek. And they ignored the reality that the process itself would cater for such matters once it got underway.

Finally, the Crown stance proved inconsistent with what actually happened. Once there was agreement about a settlement, a global sum and its determination process, Sir Rodney had control over any remaining procedural issues.

So ultimately the Crown's apparent rationale for not dealing or seeking pre-action was set out in the Crown Law Office's letter of 2 March. I won't go into that again.

In my view, in the final analysis there was from the start ample information before the Crown to suggest a high probability there had been non-medical use of ECT and Paraldehyde in a systematic and unlawful manner over a long period at Lake Alice. There was sufficient evidence before the Crown Law Office to at least suggest there was good cause to suspect that applications of ECT and Paraldehyde were punitive and a form of child torture.

Therefore, the shear gravity of the allegations suggested that urgent action should be taken to confront the issues for whatever they may prove to be. Until Helen Clark was elected, the Crown took quite the opposite approach.

If, on preliminary investigation, there remained a reasonable prospect of the allegations being true in some degree, why then would the Crown seek to defend its position? If an agent of the Crown has acted unlawfully, then rather than concealing and attempting to minimise such legal breaches, I think the better course of action was to address and confront the issues for whatever they may be.

Q. I'll just ask you to pause there. I think you then go into the apparent injustice which emerged later on. Perhaps we'll come back to that after we've talked about the resolution. But you mentioned there the change in approach under the Labour Government which succeeded the -

A. Yes.

Q. - national Government. And I think that had its origins perhaps in some lobbying, informal or otherwise, that you undertook while the Labour party was in opposition in around 1999?

A. Yes. So should I continue from paragraph 230?

Q. Yes, and if you're able to summarise as you go it might be helpful as well, just looking at the time.

A. In late 1998 Wyatt Creech became the Minister of Health. I became aware that he had publicly stated that the National Government's position was that there would be no

settlement for the Lake Alice group without a court judgment. This certainly came as news to me.

I approached the opposition health spokesperson to see if they might pose questions to Mr Creech during question time in parliament. Annette King's staff referred the matter to Helen Clark. The Labour caucus then decided that the leader of the opposition would pose questions to Mr Creech.

I listened to the session on the radio, I think it was Tuesday 30 March 1999. Mr Creech maintained there was no possibility of an out of court resolution. Helen Clark questioned him on various points and he responded with prepared answers.

But as soon as that had finished, I e-mailed Helen Clark thanking her for her efforts and I asked her specifically if Labour was elected to Government at the end of the year she might consider revisiting the method of resolution at that time. She'd been highly critical in parliament of National's intention to resolve it through the court, and she interpreted that, as I did, as simply a method of reducing the fiscal impact of these events.

She issued a media statement later that day to that effect, and tried no doubt to gain some political mileage out of that, but essentially she was happy to re-enter negotiations to find another measure of resolving the matter if they were elected to Government.

Q. I think you then talk about how you made use of a contact you had in the Labour Party, Tony Timms?

A. Yes.

Q. And perhaps if we can fast-forward to the top of page 87 which is 243.

A. Yes.

Q. This is after the new Labour Government had formed a Government.

A. Yes. Yeah, I simply used Tony Timms as a mechanism to find out what Helen Clark's intentions were and she made it very plain she wanted to resolve the issue and confront it. So against that background, I did receive a telephone call from Denis Clifford of the Prime Minister's office in April 2000 ensuring me that matters were going to progress. But I think it was really when I decided to engage with David Caygill that we began to make substantive progress in the matter.

If I turn perhaps briefly to 257 if it would help the Commission on how the quantum was reached.

Q. Mmm.

A. In consequence of the letter of 2 June 2000 from Denis Clifford, Department of Prime

Minister, we moved into a process now with Hamish Hancock at the Crown Law Office as to the form of an alternative dispute resolution process. Suffice to say there was considerable correspondence and discussion, this was quite amicable as to the various options that might be available. But again, slowly there was a hardening of attitude, presumably within the Crown Law Office, but certainly in the communications.

And I received, this is at paragraph 261, I became concerned the Crown Law Office was not acting in accordance with the express will of the Prime Minister who had confirmed on the same day that we were served with court applications by Crown Law. So on one hand we've got the Crown Law Office proceeding down a court path, we've got communication from the Prime Minister that she intended Government to settle those claims without recourse to court proceedings. So there seemed to be a disconnect between the Crown Law office and the PM.

At 264 I refer to arranging to meet with David Caygill to see if he would act as an intermediary to assist matters. Obviously as the former deputy Prime Minister in Labour Government and as a partner in a law firm he had good standing to carry out that role.

He agreed to do so, and we then got into a wide discussion as to various ways in which, again, we might be able to package some sort of resolution process. Now at paragraph 268 he secured a meeting with Solicitor-General, Terence Arnold, on 8 May 2001. In the course of that meeting he managed to move the Crown to a position where, instead of wishing to argue liability and quantum in some form of arbitration process, the Crown was now amenable to putting a global settlement sum on the table and moving directly to full and final settlement.

I thought that was a pragmatic and decisive approach by the Solicitor-General. We would have a tangible outcome of some sort. So the question then turned to well, what should the global sum be. At 271 the Crown's initial offer was for $4 million, which I think was calculated literally on an average payment of $40,000 per claimant. But that would plainly be insufficient because of the legal costs which our clients would have to meet. The costs of any post-settlement process which would be needed to divide up any global settlement sum.

So I requested the Crown appoint a determinator, because although I might hold a global sum, I was no better positioned than anyone else to determine what each claimant should properly receive from the global sum. There was a wide range of individual experiences at Lake Alice, so I couldn't enter into a global settlement without the extra safeguard of having a suitable expert to determine how that global sum should be divided

between the class members.

I proposed the appointment of a retired High Court Judge. Sir Rodney Gallen was duly appointed, he was from the Court of Appeal. The Crown offer increased - sorry, we made a counter-proposal to $6.5 million.

Q. Can you enlighten us as to how you arrived at that?

A. Simply by calculating the - judging whether or not there was an opportunity to negotiate a higher sum than the $4 million of itself, counsel was very cautious about that. We were exposed to, you know, the limitation issues we've described before. The legal costs were very plain, we wanted to have clients receiving their monies exclusively of legal costs, we threw that into the mix and went back with the $6.5 million. On the understanding that in a courtroom, the vast majority of these claims would have been struck out. We thought if we could achieve that then again we might have achieved not wholly but partly the objectives that our clients had in the outset.

So you have to take into account the time cost stress, inconvenience, litigation risk and I really emphasise the stress factor for clients had we adopted another pathway. In any event, the proposition was put, Solicitor-General expressed no reservations and agreed to put the matter to Cabinet.

Q. Again, can I just pause you there for a moment. Some of the evidence we heard from survivors last week and in statements lodged they've made comments that from their own perspectives they didn't seem to be very involved in this process, in determining the amount, or there was insufficient consultation with them about these things. Have you got any comment about that?

A. Yeah, I don't think that was necessarily the case, although I can see how some criticism may arise. It's very difficult to go to a disparate group, essentially we have individual plaintiffs here, we're still managing it as if it would be a class. So in a class action situation the class counsel has particular duties in relation to how you do manage the class etc and your relationship with the class, essentially taking exactly the same result.

What we didn't want was to write to 95 people and say the Crown has offered X, we think this, what do you think? I would have been then exposed to the risk of this information getting out into the public, this is a private process, there was a real need to keep it confidential. And I think at the end of the day having 95 different points of view would not necessarily have changed the overall equation as it sat between myself and counsel, and we had David Caygill, himself a lawyer, as an intermediary in the process. So I don't think there was a direct request made of individuals to approve steps in the

negotiation process.

Q. Were your terms of engagement sufficiently broad to authorise you to -

A. Yes, I believe -

Q. - to engage that process?

A. Yes. So we put the matter to Solicitor-General, he came back saying he'd put the matter to Cabinet, and I think it was 7 June David Caygill confirmed that Cabinet had approved the settlement sum of $6.5 million and the additional costs of the determination process itself.

CHAIR: And we're now at 2001.

A. Yes.

Q. Just keeping a track on time here.

A. I'm not aware of what the cost to the Crown would be for the whole determination process. They did pay out costs on an hourly rate basis going through that, and of course they paid for Sir Rodney Gallen's services, and there were trips to three or four locations around the country so he could meet clients.

QUESTIONING BY MR MOLLOY CONTINUED: Then you talk over the page about Sir Rodney Gallen's obvious credentials.

A. Yes.

Q. As the longest serving judge?

A. That's right.

Q. Former Court of Appeal judge, spoke Māori?

A. Yeah.

Q. Was the convenor of a Māori Synod and trustee of the Mahi Taki Trust and, of course, had chaired a Commission of Inquiry into Oakley I think in the 1980s?

A. Yes.

Q. So he was appointed as determinator and I think came up with a means of identifying a rough guide to how people's -

A. Yes.

Q. - sums might be allocated?

A. Yeah, I might mention that Sir Rodney was briefly involved in the way this process was designed and finalised. But he was charged with determining the apportionment of the award between the claimants. So this is not a situation where Sir Rodney would take an individual's circumstances and then pluck a damages or compensatory sum out of the air as he saw it whether based on law or otherwise. He had to take a fixed sum and then apportion it fairly between them, and that required a special mechanism.

So we met with him and at 284 I detail the very steps in that. Now ordinarily that might be something we could skip over, but I think it might be advantageous for the client group to hear exactly how that process worked.

CHAIR: Yes.

A. He was charged with making GRO-C GRO-C GRO-C GRO-C GRO-C. Therefore, he apportioned a known and fixed sum of 6.5 million and he had to establish some form of reasonable proportionality as between client claims.

People had many different experiences and so we listed them on a spreadsheet. An example of that was attached to one of the exhibits that we have attached to this brief. By placing them on a spreadsheet in this manner, it was possible to see which clients had which specific experiences. For example, not all clients had received ECT, some had experienced only one or two objectionable experiences, whereas others had suffered a majority or even all of them

So in considering a particular client's experience, it became necessary to provide some sort of weighting. For example, if one individual had only received ECT once, but another had received it 25 times, did that mean the second individual should be ranked as having had an experience that was 25 times worse than the first one.

Now the evidence suggested that those had suffered ECT on many occasions at least had a reasonable expectation as to what they were about to experience. However, individuals who had experienced ECT on only a few occasions were often seriously traumatised. And there was also evidence that persons who never received ECT but who nevertheless regularly observed others receiving it and the traumatic aftermath were often more distressed than those who actually experienced it.

So for these reasons and others, Sir Rodney decided a weighting based on a 10 point scale should apply. Those suffering less trauma might receive a lower ranking, those with extreme trauma might receive 9 or 10. So it was a relativity proportional sort of mechanism, and in practice it worked very well.

Once he came to his preliminary decision on an individual's experiences, he would meet with myself and a colleague, and we would discuss his thinking on the point. Our role

was simply to point out issues that he may have overlooked, or make suggestions as to any matters that he might yet want to take into account.

So there was no need for advocacy of any particular individual's position over another, it was simply making sure he had taken all relevant material into account. It worked extremely well.

Shall I turn now to the report that he later made.

QUESTIONING BY MR MOLLOY CONTINUED: Yes, thank you.

A. During the assessment of the position, Sir Rodney was at pains to try and give every claimant the opportunity to meet with him and describe their experiences. In the final analysis, about 41 people met with him, it simply wasn't possible for all people to come from their various locations to such meetings.

Halfway through the whole process, Sir Rodney came to me in a tea break. He asked me how I felt about the process and whether it was achieving what we hoped it would. I confirmed that I thought the process was excellent, but he asked if I had any regrets or thoughts about how it could have been done differently.

After thinking about it for a moment I said my only regret was that when we completed the process he was obliged to give me a list of names alongside which there would be a dollar figure. That would enable me to do full and final distributions to clients, but that document would not reflect what truly what happened at Lake Alice. Indeed there would be no official record of what had truly taken place.

Although there was no requirement for him to produce anything more than the list of names and numbers, I thought there was a risk that this dreadful saga would pass into history without any definitive judicial or other record of what had taken place, and therefore there was no prospect of Government developing any future preventative mechanisms. He nodded but said nothing.

About three days later he approached me and said he'd reflected on my comments and decided he would write a report for the Solicitor-General. He thought that might be passed on to the Attorney-General as well. He then asked whether I could read his draft.

I agreed to do so and thought it was an outstanding summary of what had taken place and I had no suggestions as to changes. I thanked him for his efforts, expressed my hope it might achieve some wider good, and I think his report did provide such compelling insight into what occurred at Lake Alice. The Prime Minister was moved to create a second determination process and provide redress for the many who had not come forward into our first process.

I now turn to the question of payment of my client's legal fees.

MR MOLLOY: Just before you do, ma'am, we probably need to manage time a little here.

CHAIR: Yes.

MR MOLLOY: So I think leave has been granted to other parties to question Mr Cameron for about half an hour.

CHAIR: Yes.

MR MOLLOY: Really it's - I'm in your hands as to whether you wish to take another break. We have one more witness today who I think will probably take an hour. I don't know whether you're in a position to sit until 5.15 or whether we need to finish by 5.

CHAIR: I'm sure we can sit a little bit longer on the basis our transcribers and people are up to that.

MR MOLLOY: Indeed.

CHAIR: Shall we start at the beginning and check to see that those who have been granted leave want to exercise their rights under that leave. So we'll start with you Ms Joychild.

MS JOYCHILD: Yes, ma'am, I would like to exercise -

CHAIR: You'd like your full third, how long was it, 20 minutes?

MS JOYCHILD: Well I can talk fast.

CHAIR: We know that but you know what happens when you do talk fast, Ms Joychild.

MS JOYCHILD: We understand each other, yes.

CHAIR: Yes, we do have record-keeping, so I don't want up to feel that you must rush through. I'm just trying to - how much time were you granted, 20 minutes?

MS JOYCHILD: 20 minutes.

CHAIR: Yes, Ms Feint what about you?

MS FEINT: Yes, I would like to question as well.

CHAIR: For 20 minutes.

MS FEINT: Yes.

CHAIR: All right, so that's the starting point. So let's work back. If we finish at 5.15, do the maths for me Mr Molloy.

MR MOLLOY: Reconvene at 4.15 for an hour, break at 4, we'd need to finish - I need to finish Mr Cameron in a couple of minutes, and then you would need to be happy to continue without a break. You might prefer to take a short break.

CHAIR: I think we might take a 5 minute stop.

MR MOLLOY: To allow at least some respite I think for -

CHAIR: Exactly. It's regrettable to all of us that we have to rush you through, Mr Cameron, but

you've been through this in court no doubt yourself many times. If you could do that, we'll finalise the last few important matters and then take a very short break and then we'll start with the questioning from counsel.

QUESTIONING BY MR MOLLOY CONTINUED: Mr Cameron, in your statement you've gone through the fees and the calculations. I think I've already hinted that some of your clients, former clients have expressed concern at how high they were, and you've outlined your perspective on that in the statement.

There are also a couple of other things that are probably worth us touching on if we can. One is the complaint that you assisted to the Medical Practitioner's Board of Victoria in Australia. If you can touch upon that briefly. And also the fact that you assisted, I think, 34 of your former clients to make complaints well-substantiated to the New Zealand Police.

A. And you'd like that summarised in 5 minutes? I will do my best. Could I mention on the question of fees, all clients had a clear understanding in terms of the contract that they were only going to be paying a small amount of money, as it turns out if they chose to do so on account of disbursements. They all understood that it was essentially a contingency thereafter in terms of payment of fees and they would have to come out at the end.

We also informed clients that we would try and obtain Crown funding, in other words that we would either be paid in a process or that somehow the legal fees would be addressed at the end.

Now from the Crown's point of view essentially the fees were addressed at the end, and it was pretty cavalier as to whether or not, because it was a contingency, that proved to be a larger sum than what might be normal.

Contrary to public belief, encouraged by the Evening Post and probably some Chinese Whispers in Wellington, there was not a single fee of about 1.8 million fee or whatever the figure in the newspaper was. There happened to be a large sum of money billed simply by virtue of the terms of the contract, the risks that I'd taken on and we had 95 clients so it added up to a large amount.

But individually those clients, my own fee was kept to under 30%, not 40%, that I'd put there. We had, as I say, incurred the liability in terms of disbursements of $100,000, there was - I paid for a QC, in fact two, to give advice. With this sort of settlement you always anticipate there'll be somebody who will complain to the Law Society, so you need to do things impeccably.

Contracts naturally provided for us to apply principles of charging. We did so. There was a general file against which most of the work in progress was recorded. Each

client had their own individual file, so where there was some work on that that had to be taken in account. So the general file was averaged out and this was on a pro-rata basis, according to what they got. We added their own individual work in progress and each client received an individual bill.

Knowing that there might be some debate, I instructed Colin Pidgeon QC, who I'd never had anything to do with but came highly recommended to me. He provided a 19 page opinion, and in one sense I think he said - probably implied that I was a fool to take it on because of personal risk. At one stage my firm's overdraft was about 630,000. I had to sell a family trust asset for about 420,000 to put some money back in the tin to keep us going. And he was very complimentary about the extraordinary outcome.

Q. When did you start work on the matter?

A. Sorry?

Q. When did you start work on the Lake Alice matter?

A. 1996.

Q. When did you render your first account?

A. When it settled, I think it was late 2001.

Q. And a copy of Mr Pidgeon's opinion is annexed to your statement?

A. Yes. And he deals with the whole nature of the contingency arrangements, whether it was fair and whether it complied with the Law Society position. So with all of that I was comfortable. I also had verbal support from John Billington who was counsel in the case, I took that into account in doing the bills.

We did the distributions and as expected we had I think three client complaints. They were referred to the relevant law society. There was a special committee set up to hear those complaints. They went through everything from top to bottom and said I'd acted entirely properly and all the accounts were in order. So there was nothing whatsoever in terms of the complaints that could be sustained.

When that was over, or during this process, when the Evening Post made its - issued its article, Helen Clark was concerned to hear that the evil Mr Cameron had apparently taken about a third of the monies out of the settlement. She obviously contemplated that costs might have been on top, but in any event she detailed David Caygill to come and see me. I presented him in a weekend meeting with copies of our terms of engagement, our contracts, Colin Pidgeon's opinion. I think there was some Law Society material at that stage and gave him the full position. So had gone a long way out of my way to make sure the accounts were fair and reasonable.

So he advised the PM and I was then telephoned and advised that the Labour Government would take no further interest in the matter.

Q. After the first round there was then a second round later on, which again you refer to in your statement, where compensation was paid to a second round of claimants who had not been part of your litigation and they received payment in full. Can you understand from the perspective of the people you acted for the disparity which exists -

A. Totally.

Q. - may seem completely unfair?

A. I think, well a number of mistakes I think were made by the Crown in this whole process, but there was sort of a pretence that the part 2 process was wholly separate and you can say well, the first part was finished so this must be separate. From the clients' perspective this was probably a continuation, everybody had been involved in the same affair, everybody had been affected the same way, and yet we had been subjected to costs and these people weren't.

Now there was errors made probably by the Crown if it wanted to achieve its net in the hand objective, which I think was conceptually wrong. People who bring a case, establish a precedence, carry the cost, the rest of New Zealand society takes advantage of that, that's just the way life works out.

But there were mechanisms by which the two could have been brought together, blended together and the whole costs thing could have been spread. I think that notion of cost spreading so the first group should have had their costs somehow spread to the other, or the first group should have had their costs paid for in full in addition to the compensatory payment. Because the 4 million distributed between 95 wasn't a fair compensatory payment, that's true.

Q. So again, just coming back to the question, for people who were involved in that first round and who had costs deducted, can you understand that from their perspective?

A. Yes.

Q. There's an element of injustice about that?

A. Yes, absolutely.

Q. I'm looking at the time, it would be helpful if you could touch on the complaints forwarded to the New Zealand Police.

A. Certainly. Do you have the page number just handy? Here we are. We had given consideration right at the beginning of the process as to whether we should complain to the Police. We had limited information at that stage and although I think the pattern was quite

clear and it was very concerning, I, having spent 10 years in the New Zealand Police, didn't hold much hope of an effective inquiry being carried out at that point. So I thought the better course was to put our limited resources into a civil litigation process, and we had the option to present complaints at a later date if indeed that further evidence added weight and suggested that we should.

In the final analysis I did this and I might mention at no cost to clients. So this was a position where we went to the clients after and said "All right, you've all received your money, some of you have expressed real concerns about these issues and had talked about Police complaints that had been raised once or twice. How many of you are of the view we should proceed?" And I think about 34 or 40 - sorry, I might find -

Q. 34 of your clients you say?

A. Yes, decided that yes, they would like me to prepare a complaint. So I did prepare the complaint and 16 December 2001 I wrote to the Police Commissioner, informed him of the background facts etc. I had made arrangements to meet with somebody at the Police National Headquarters so that I could actually give them a lot more information face-to-face. I don't remember who it was that I actually met at that time - this is paragraph 367 - but I arranged - 34 people, that's right - I arranged to then prepare the complaint and formally lodge it. I think that came in March. Nevertheless, the same information, essentially, that we'd given the Crown was given to the Police as to why ECT and Paraldehyde should never have been applied in these circumstances.

I made it very plain to them that we believed there had been child torture. We gave them the client witness statements, the relevant medical evidence, I think some other witness statements. So there was a very large packet of information supplied.

I suggested - this is paragraph 378 - there was good cause to suspect a commission of offences, so at least I expected the threshold for the Police to commence an investigation had been met and had a duty to make appropriate inquiries.

The short answer is that after lodging that I don't believe I received further communications. I did expect Police would contact those people who were part of the complainant group, but I really didn't hear anything more.

Q. Thank you. Ma'am, I think we should probably take a break and I should relinquish the microphone.

CHAIR: That last point, you never heard, you never received a response to the complaint at all?

A. Well, I'll just double-check this perhaps during the break, but no, that is my understanding.

Q. Thank you. We'll take just 5 minutes or so. Thank you.

Adjournment from 3.34 pm to 3.47 pm

CHAIR: I'm sure there's not going to be a competition about who goes first. Have you reached agreement between you? Very well, thank you Ms Feint.

QUESTIONING BY MS FEINT: Tēnā koe, Mr Cameron, my name's Karen Feint and I'm appearing for the Crown in this Inquiry.

I think the key point of your evidence, is it not, that overall you achieved a very satisfactory outcome for your claimants in reaching that settlement?

A. My feeling is that it's a less than satisfactory outcome had all things been equal and we'd been able to get an independent party to determine the matter of quantum in an unfettered manner. But in terms of the choice of a global settlement sum, as against the alternative of going to court, yes, I think it was a reasonable outcome.

Q. Well, you say that in your evidence that your clients received what they had so vigorously sought in terms of the ADR process and a fair settlement, so your issue is over how long it took to get there, is it not, and the costs that you incurred in doing so?

A. I don't have an issue. I've been asked by the Commission to relay the facts of my experiences and what occurred and I've done that, so I'm not quite sure what you mean my issue is, I'm not here to advocate for anything.

Q. Were you aware that you achieved with the $6.5 million settlement the maximum that the Cabinet had approved?

A. No.

Q. In terms of negotiating position?

A. No, I'm not aware of that.

Q. Would you agree that a four year period from the time that you approached the Crown in July 97 until when you achieved the settlement in mid-2001 is, although it took longer than ideal to reach a settlement, it's nonetheless, I would suggest, faster than proceeding through the courts, particularly if there were appeals involved, do you agree with that?

A. That's possibly the case.

Q. And you're open in your evidence, aren't you, that reaching a high level political settlement was the best strategy, because there were legal barriers in terms of going through the courts, so it would have been a high risk strategy to proceed through the courts, wouldn't it?

A. Yes, it would have been.

Q. You say that you proposed an ADR model based on the Cave Creek model. But would you agree that it's not an entirely apt comparison because, well, there were significant differences; the Cave Creek ADR process was agreed to after a Commission of Inquiry in

which the facts, and therefore DOC's negligence in building the platform, were established, did it not?

A. I think that's a happenstance of the circumstances. I don't believe that a determination process must be reserved to after a court process or a Commission of Inquiry. I think where parties have a dispute, the parties themselves should get together and try and design a mechanism. And I think it's to fair to say that because we're all damn lawyers, we think in a certain box, rules of evidence, of procedure tend to control our thinking, our experiences of the law.

So in terms of dispute resolution, we have the opportunity to, at one extreme, go to court, you know, we all know the rules of that game, short of that arbitration, very similar, both having the same problems of time, cost, hassle, litigation risk etc. And the only other option, apart from straight-out horse trading, is mediation.

I think John McGrath was a very wise man and the determination mechanism is something where you're actually asking a party to bring you together and be proactive instead of neutral like a mediator, and has the power once - if the discussions don't lead to anything, to bring about a binding and impose a binding outcome. It's a very useful device and I don't think, you know, lawyers have explored this enough, and it doesn't necessarily have to come after that, it is just the way it happened.

Q. Can I ask for document CRL0044150_26 to be brought up please, which is the Crown Law advice of 4 February 1999. Just while we're waiting on that, Mr Cameron, you speculate in a number of places in your evidence about what Crown Law's instructions were and we can agree that there's no need to speculate in this Inquiry, given the Crown Law has waived privilege and all the documentary record is before the Commission.

A. I haven't seen any of that, but I fully accept that they have instructions.

Q. All right. So this is advice from Crown Law to the Ministry of Health dated 4 February 1999. If we go to paragraph 10 of that advice, and so this is advice where the Crown Law Office is evaluating the claims. And it says there:

"...it should not be forgotten that the present allocations relate to events which were alleged to have occurred over 20 years ago at a time when all the complainants were very troubled, if not mentally disordered, adolescents. Moreover, the fact that the allegations will undoubtedly be strongly contested by the other participants renders these claims very different from those made in, for example, the asbestos and Cave Creek cases, where the facts and therefore the Crown's basic liability, were more or less accepted from the outset. This last point in particular may have considerable bearing on the choice of the

most appropriate means of disposing of these claims."

So it would appear the point that Crown Law is making there is that they need to evaluate those claims before advising the ministers on a choice of process.

A. Are you saying that the Crown Law Office should investigate those claims before advice?

Q. Their advice is that they did not have enough information to establish the Crown's liability at that point.

A. Well, I disagree, I guess, to the extent that I felt they did have more than enough information to commence an inquiry. The problem that we're facing, I suspect, is that the Crown was faced with the horrendous conflict of interest. On one hand it's got the obligation to protect these people, to investigate allegations of certainly the allegations in the nature of torture they've got international duties to perform. And yet at the same time this can be portrayed as a legal challenge. I was at great pains to try and avoid the legal challenge concept and to move into a discussion of how it might be neutrally resolved. But once you take a defence posture, I think the Crown was faced with conflicts.

So therefore it should have been seeking an inquiry by somebody independent and then awaiting the results of that, and indeed that was something that we were almost - we were actually advocating for, get somebody independent to inquire.

Q. And if we go down to paragraph 18 of that advice, Crown Law there is referring to the emotive aspects of the claim and the - you see they say in the last paragraph of that first - in the last sentence of that first paragraph, they acknowledge that it would be foolish in any assessment of the overall merits to ignore the facts of the claim. So they're referring there to the moral aspects of the claim that the claimants were children, that they were subject to psychiatric treatment that's regarded as abhorrent, and that they were wards of the State.

Then if we go - so in other words they're not only relying on an assessment of legal liability, but also considering the moral position that the Crown is in. Would you accept that?

A. I guess I have to accept to the extent that that wording implies that, their overall behaviour didn't suggest there was much weight being attached to the moral point of view but -

Q. If we go down to paragraph 40 of that same document, you can see there in the first sentence that the key question which legal advice cannot answer, is whether ministers wish these claims to be dealt with on their merits. That really sums up the position, doesn't it, that it was - this case called out for and what it achieved was a political settlement at the highest levels of Government where ministers assessed the position and decided according to the merits of the claim and the public interest what was the best outcome for all. Would

you accept that that's -

A. Certainly I think the Minister's need to take into account those wider issues, that's a matter of judgment at that level for Cabinet. However, they need to be fully and fairly informed. I have - all this describes is an appropriate ADR mode, if that's preferable, then there are advantages in doing it that way. But if they want to resist all claims at all costs, then presumably there should be litigation. I have no way of knowing what other information was supplied to Cabinet where they could make a fair and reasonable and fully informed assessment on those issues.

CHAIR: Could you remind me of the date of that letter please?

MS FEINT: That's 4 February 1999.

CHAIR: Thank you.

QUESTIONING BY MS FEINT CONTINUED: Part of the political reality that you dealt with, but I don't think you draw out so much in your evidence, is that you were dealing over this four year period with three separate ministers of health.

A. Yes.

Q. And two different Governments.

A. Yeah.

Q. And in effect that was part of the reason why it took so long, wasn't it, because each minister had a different approach?

A. I accept that.

Q. You refer to at paragraph 212 of your evidence to the meeting that you had with Bill English. And I wonder whether we could bring up the next document, CRL44149 number 10, which is the Crown Law file note of the meeting you had with him on 6 August 1997. We can see, Mr Cameron, that it's a file note dated 7 August 1997, and if we just scroll down it shows who was present at that meeting that you had with the honourable Bill English and Ministry of Health officials.

And then if we go down to paragraph 2, sorry page 2, you see at the top of the page there it sets out the four options that you wish to canvass with the Minister at that stage?

A. Yes.

Q. And so you were proposing essentially four different versions of an ADR process?

A. Well, this was the preliminary stage where it was just simply citing what the apparent options were. I think all parties agreed they were the ones to talk about.

Q. And then if we go down to halfway down page 3 where there's a comment from the

Minister himself where he says he agrees with you, your viewpoint that a Commission of Inquiry would not be useful, but then he says other options warrant canvassing. Involvement of other Government departments is new and requires consideration. So that's a reference to the fact that this claim required a multi-agency response, didn't it, there was not only the Ministry of Health but also the DSW, Ministry of Education and Treasury that would need to be involved in any settlement?

A. Yeah, I didn't - there was no discussion, I didn't agree with him that the Commission of inquiry would be of no value. But I simply accepted his comment on that point. And it was completely obvious that the other Government departments would be involved, yes.

Q. And if we scroll down to the very end of the minute, there's no record anywhere in this file note of an agreement that he would go to Cabinet within a six week period at that point, which suggests that it wasn't something that he had understood was an outcome of that meeting?

A. I understood to the contrary. My recollection is as follows or as I put out in the brief. I certainly accept there was no commitment that the matter was a matter of exploration for officials and I was accepting of the fact it may go beyond six weeks.

Q. Given the need to co-ordinate across all those Government agencies it would be surprising if he could have got an outcome from Cabinet within six weeks, don't you think?

A. Well, not necessarily, because to my way of thinking at the time Ministry of Health was the primary party to deal with. Education was entirely irrelevant, might have been connected in some fashion, but it had nothing to do, as far as I could tell, with the application of Paraldehyde or ECT. And it was really a matter for the Crown to decide for itself who would take responsibility and leadership in this. So inquiries of some of the periphery agencies I didn't think would take very long.

Q. Can we go now please to document MOH 469 number 1, which is a briefing from the Ministry of Health to its minister, 29 September 1998. I just wanted to put this document to you because you say - you accuse the Crown of delay a number of times in your evidence, and this report here is a briefing from the Ministry of Health to the Health Minister, Bill English in September 1998, and if we look at paragraph 1.

A. Sorry, who did you say issued the report?

Q. The Ministry of Health.

A. Okay.

Q. This is officials briefing the Minister. And they're reporting to the Minister that he had requested this timeline after receiving a copy of the letter from you to Health legal alleging

that the Crown had deliberately delayed its response to the issue. And if we go down to paragraph 6 you'll see that there's a timeline there. So you first approached the Government in July 1997; correct?

A. I'd have to check the brief for the date but I'll accept that for the moment.

Q. And then if you go down to the next page, by September 1997 the Ministry of Health has requested a list of clients, authorities to act and details of anticipated costs from you. And then if we go down to February 1988, the Ministry of Health is still requesting that, has made three requests, you respond apologising for the gross delay in this matter. And then down to June 1998, the Crown is still asking you for that information but you still haven't provided it by then, have you?

A. No, not at that stage in respect of that information.

Q. And then if we look at July and September 1998, you provide to the Ministry of Health the affidavits and draft statement of claim setting out your allegation. So it's not until July, September 1998 that the Crown has precise information about the allegations made by your clients and evidence of what they suffered in Lake Alice?

A. That would be true. My thrust earlier, I think I've made it very clear, was that the Crown was being asked to investigate and there was quite sufficient information right from the outset for them to start an appropriate inquiry process. More precise information could have been developed and fed into that process at any point along the way. I think if we developed this type of list or timeframe from our side of the fence and put the two together, we'll see faults on both sides.

Q. Thank you. I think it is relevant from the Crown's point of view that the information it had included inquiries from 1977 which had reached contrary conclusions, and strongly contested - the allegations were strongly contested by various staff of Lake Alice.

A. But then it was given a lot of fresh information.

Q. Yes, but it took over a year for the Crown to get the information that it needed to evaluate the allegations that your clients were making.

A. Well, the information that's said in there, yes.

Q. I think in the interests of time, ma'am, I'll wrap this up fairly quickly. I'll just point to one further incidence of the different narrative of the Crown and, Mr Cameron, in terms of what was happening. So if I can take you to paragraph 261 of your evidence please, Mr Cameron.

A. 261?

Q. Yes. At no stage of the narrative, you've said back on the previous page that in December

2000 the Crown had applied to the court seeking orders for medical examinations from the plaintiffs. And you say in 261 that you were becoming concerned that the Crown Law Office was not acting in accordance with the express will of the Prime Minister who confirmed on the same day we were served with those court applications that she intended Government to settle these claims without recourse to court proceedings.

I'd just like to take you to the Solicitor-General's advice in respect of the allegations that you were making, if I ask for CRL44434173 to be brought up please. Because once the Crown had applied for those medical examinations you had written to the ministers complaining about that, hadn't you, and suggesting that there needed to be an independent QC appointed to review the conduct of Crown Law?

A. I haven't referred to that in the brief, and it hasn't been discussed in my office in preparing this, but I do recall that something like that did happen.

Q. If you look at paragraph 1 of this memorandum. So this is from the Solicitor-General to the Prime Minister in March 2001 and the Solicitor-General is reporting to the Prime Minister that you've written complaining about the Crown Law off's handling of the claims against the Crown. You ask her to appoint a QC to review the Crown Law Office's handling of the matter and report back to you. "The purpose of this memorandum is to advise you of the present position and to suggest a draft reply."

And if we go down to paragraph 5 and 6 please. So we've set out there that by that stage the Crown had accepted that it would investigate a Cave Creek ADR-type process?

A. **[Nods]**.

Q. And it sets out in paragraph 6 that in order to facilitate establishing this type of resolution process, the Crown Law Office had asked the claimant's lawyers to provide the following information. In 6.1, a complete list of all the claimants. The purposes of this is to ensure, so far as possible, that a comprehensive settlement can be achieved. Secondly, a fully particularised statement of claim for each claimant.

There are two reasons for this request, first if the informal process is unsuccessful the claimants could not complain they were lulled by the Crown into thinking they did not have to make formal claims, and secondly the existence of detailed formal claims will enable the Crown to prepare its defence.

Thirdly, the Crown Law sets out there the medical examinations had been requested under the Judicature Act, because despite your comments that psychiatric injury is not an important feature of the claims, in fact in the existing statements of claim and the supporting evidence psychiatric harm features prominently. And they go on to say that the

medical examinations are required to be under court direction to expedite the process so that examination dates can be applied for and because these examinations are expensive for the Crown, it's essential that the Crown can thereby use that information in court as well.

If we scroll down to the next paragraph. The intention is to get the exercise done properly. The first time thereby saving time and money. They note that they have tried to agree these steps with you out of court. You sought to circumvent the process. And a further point of difficulty is that you wanted the Crown to relinquish defences which you describe as technical and the Crown notes it sought a compromise here which involves waiving the defences in the context of a mediation arbitration but only to the extent of any agreed minimum payout.

So that advice sets out, does it not, Mr Cameron, that Crown Law was acting in accordance with its instructions from the Prime Minister and that there were legitimate reasons for it to seek medical examination before the court?

A. It sets out the Crown's advice to ministers at that time. It shows that the Crown was addressing issues of litigation nature. We were attempting to obtain an ADR process. The messages that were coming to me, shall we say from a political level, or the intelligence that we thought we were receiving at that level, was not compatible with the actions of the Crown in serving applications seeking discovery of medical records of people and submitting them to medical examination.

So the Crown may have viewed these as, you know, legitimate reasons for telling the ministers this is the path that might be preferable. I was not privy to any of this information. Had the Crown had a more open approach and discussed these issues in some form with us we might have had a different perception to the one that I had in paragraph 261 of my brief.

Q. Thank you Mr Cameron. I think probably in the interests of time we might just leave it there. I'll just ask one final question. Given the primary objective, you say, of your clients, one of them was to achieve accountability for what had happened to them; do you think with the benefit of hindsight perhaps you should have prioritised approaching the Police and looking at a potential prosecution over a civil settlement, given that it resulted in a five-year delay in lodging those complaints with the Police?

A. I've given my reasons in the brief very clearly as to why we did not pursue a Police prosecution position at the outset with limited information. The fact that we delivered a comprehensive brief I think in 2002 or thereabouts and nothing happened probably reinforces the fact that my perception earlier on was correct that nothing would happen by

taking that path with the Police.

Q. But prosecutions are time sensitive as well, aren't they, given that Dr Leeks was in his 70s by the early 2000s?

A. My clients' objectives were not described in calling for accountability, it was prevention, apology, compensation, and punishment was the only other ingredient. So accountability in a sense of punishing those perpetrators was certainly an issue. Even if it had been a successful prosecution of Dr Leeks, that would not necessarily have meant anything at all for my claimants.

Q. Thank you, for your evidence, I have no further questions.

CHAIR: Thank you Ms Feint, yes Ms Joychild.

QUESTIONING BY MS JOYCHILD: Mr Cameron, I act for the group of Lake Alice survivors who, as you'll know, is a disparate group.

A. Yes.

Q. Disparate group. First of all, I think most of them would acknowledge that but for the work that you did, this terrible issue, this terrible episode in New Zealand's history would have never seen the light of day, or is unlikely to have seen the light of day.

A. Thank you.

Q. It seems to me from your evidence you've accepted that the Government should have paid that first group of clients' legal fees?

A. They needed to take a more sophisticated approach to how they addressed it. In fairness to the Crown, at the point they decided to put a global sum on the table, they did not fairly contemplate there was going to be a two part process. Nobody knew that Sir Rodney Gallen was going to make a report and that it would have the effect that it did. So, you know, I think some room for concession there for the Crown.

Q. They did know, though, didn't they, that that 6.5 million was going to have to include your legal fees?

A. Yes.

Q. And that you'd been carrying the case for five years?

A. Yeah, and they knew not only that I'd been carrying for that period of time, they knew that it was going to be a quasi-contingent arrangement, and that on normal principles there would be a substantial payment involved. Now the fact there was it had little or very little premium involved above the actual work in progress and that we carried considerable costs, we worked for a year beyond closure of this matter without payment.

Q. Yeah. Okay, that's understood. Now just back to the statements of claims that you filed.

You have said that there was an extreme - immense risk of litigation if it went down the litigation path. I put it to you that that's a bit of an overstatement and I'll tell you why. The first group that you filed 56, they were all filed - they all related to being in Lake Alice before 1 April 1974, weren't they?

A. Yes.

Q. So they had no problem with an ACC bar, they didn't have -

A. No, that's right.

Q. The other group, as well as the first group, all had claims of false imprisonment. That also is not affected by the ACC Act, is it?

A. Sure.

Q. So the only issue really that these people had was to get through the limitation defence?

A. Yeah, that was perceived as being the major problem.

Q. And one of the exceptions for the requirement that you file personal proceedings within two years of turning 20, which none of them could have met, but one of the exceptions is if you have a disability?

A. Mmm, that's right.

Q. So there was a defence that could have been run?

A. Mmm.

Q. Do you accept if these people had have got through these situations, they would have been potentially able to claim hundreds of thousands of dollars?

A. Yes, I totally accept that. I took advice from counsel on it, we saw approximately three people of the whole group as potentially being able to sustain a disability argument.

Q. Right. So for them, they see in their statement of claim that you're claiming $485,000 for them, then they find out that there's a settlement that where the average is around about $40,000.

A. Well, that was an average.

Q. An average, some were going to get a lot more, but no-one was going to get anywhere near, say, $200,000, were they?

A. No.

Q. So from their point of view, it was a - for many of them, even at that time their evidence is that they felt betrayed by this?

A. I don't for the life of me see how that could be the case. None of them were prepared to pay legal costs to have their own position assessed in terms of disability, give them an opinion as an individual and send them off into litigation pathway as individuals. I was being asked

to take this matter forward for a lot of impecunious people to see what, if anything, could be done and in all the circumstances it seemed plain that if we were going to address this in a comprehensive manner and it should be done as a group and done as a whole, so that the Crown had full and final settlement of all issues out of this matter. The Prime Minister likened this to essentially being like a Waitangi Tribunal claim in the sense these are ancient grievances, and the better way to address it is to confront it, expose it, and resolve it. It's better that all people get addressed in some reasonable manner than three walk away as millionaires perhaps and nobody else gets anything.

Q. Of course, but it wasn't three, I mean it was 56 at least who were before ACC and it could have been a whole lot more.

A. That is to assume they overcome the limitation issues.

Q. Yes.

A. And we're saying that's highly improbable.

Q. You're saying that was highly improbable?

A. To overcome the limitation defence was highly improbable, that was the advice from counsel.

Q. Leoni McInroe's counsel, of course, obviously took a different view.

A. And had immense difficulties.

Q. Yes, one of the reasons why they had immense difficulties, which I want to talk to you about, is the fact that despite filing their claim three or four years ahead of yours, and despite Rob Chambers calling you to let you know he was interested in joining up, this never happened. Can you comment on that?

A. No, I remember it a little the other way around. I approached Rob to have a talk about where they were up to, when there was some hint of ADR processes commencing on our side of the fence as it were. Of course ADR then later broke down and we were back into a litigation pathway. I don't know what transpired after that, so when we got the resolution with the Crown and they agreed that Sir Rodney Gallen would be the determinator and we'd go down this path I don't recall if there were communications with Rob Dobson or not. He could have certainly rung me because it was well publicised in the paper.

Q. Yes, and that's what the sense of betrayal was, it was well publicised in the paper that there had been a settlement, but they had been cut out of it?

A. Mr Dobson's client?

Q. Mr Chambers.

A. Mr Chambers, sorry, yes. Well, Mr Chambers' client was not my client.

Q. No.

A. I had no obligation to bring him into that process and I guess I hadn't turned my mind to it in going through that. Certainly, there was no reason why they couldn't have engaged in part two.

Q. Well, they did engage in part two, but by then, of course, the levels are set, the levels of compensation are set and they are set low.

A. Well, that's life. I had certainly no obligation to change my stance in negotiating a settlement for my clients because some other solicitor and their client might think that the range that might possibly come out of this process might be too low. That's for them to advocate for their position.

Q. You didn't think, did you, that it would be helpful to join forces with Mr Chambers?

A. I certainly did, which is why we contacted him in the first place.

Q. And he provided the precedent of the Statement of Claim, didn't he?

A. I don't recall.

Q. I think it's on the record that he did.

A. He may have.

Q. Yeah. Well, so it didn't happen, though, that - it's also on the record that he did ring you and talk about -

A. We did have a discussion.

Q. - his interest in an ADR process?

A. Yes, I think I refer to it in the brief, and basically if one was to be made available then he would be interested in it, yes.

Q. But you didn't see that was any - you had any responsibility to tell him that you were starting -

A. I don't know if communications were after that, I don't recall any communications and I had no obligation to him.

Q. Yes, I'm not really talking about specific obligation as much as working for the good of the whole group together.

A. I was focused on that all right.

Q. Right. Well, I guess my big question is, we've seen earlier we've seen a memorandum from the Prime Minister Helen Clark's executive assistant saying that $132 million had been earmarked by Treasury for the resolution of this matter. Yet the Crown have got away with paying about $13 million or so, $6.5 to yours and -

A. Certainly. I had no knowledge as to what the Cabinet allocation might be, I don't know of

that communication.

Q. Well, do you think, and, you know, everyone must know of the enormous burden you were under with the huge delays, and your financial position. So do you think that really that was an impact in the amount that was accepted in the end that you were over a barrel?

A. I suppose in one sense yes you're quite correct. When I obtained the $6.5 million on the table from the Crown, the matter was discussed fully with John Billington QC, the advice was that we should accept that and move ahead because our alternative was a court path which held little or no hope of positive outcome.

Q. Why didn't you come back with $20 million? Normal negotiations go backwards and forwards a long way.

A. Normal negotiations are very effective where one party has some leverage.

Q. And as time went on your leverage got less and less?

A. Well, leverage was minimal to start with. Our leverage was developed by use of the media which brought this out into the public arena, it put a ray of light on the events that had occurred, it caused, I think, some angst at the political level, there were discussions and movements taken by Government agencies as a consequence and I think we moved to a settlement which otherwise had that not been there would never have taken place.

Q. Okay. Thank you. Looking at - you were obviously aware of the Convention of Torture at the time because you use the word "torture". Did you look at the Convention in terms of what was required to - the Government's obligations were for people who had been tortured?

A. Yes, very briefly, and I took some sort of oral informal advice from around the profession. The sort of prevailing view was that human rights was not an issue that was really going to get much traction for New Zealand courts. If there were conventional torts or breach of contract situations then the normal cause of action would be sufficient to bring about, you know, a damages result, that would be the appropriate way to go and there wasn't getting a lot of movement from the courts otherwise on those issues.

Q. Did you point out to the Government or Crown Law that it had obligations to fully and effectively rehabilitate every victim of torture?

A. I believe that was brought up, and I can't point to the letter or communication, but I do recall that was touched upon.

Q. And so the rehabilitation in your mind, it was getting an apology from Helen Clark and getting some money for these people?

A. Yes. The difficulty was that rehabilitation from the Crown's perspective was buried in the

settlement. Plainly I think that was inappropriate and that people have ongoing needs and there should have been ongoing support. But that's the way it was.

Q. The fact is that you had 95 clients, it was just impossible to interact with each of them separately, wasn't it?

A. Well, not impossible, we had I think a very effective mechanism to deal with them. We had actually brought in 17 law graduates to assist with interviews and what not and there was sort of small teams created whereby there would be no problem whatsoever in contact both ways.

Q. But then the people have said, several survivors have said it was a take it or leave it?

A. It was.

Q. So if this was four years, five years down the track?

A. Yes.

Q. And there is an amount which some say shocked them, it was so little, when they thought of what had happened to them, what they were thinking they might get. But there was no independent legal advice should I take this or should I now join Leoni McInroe's litigation and go on to Legal Aid. Is that an omission that -

A. I don't believe so. I think they were given the opportunity to take legal advice in regards to settlement offer. And so I don't think there was any issue about the fact that they were there under the terms of engagement seeking a financial outcome, a compensatory outcome.

Q. Were they all told they should take legal advice before they accepted?

A. They were told that before entering the original contract, and I believe they were told that at the time of the acceptance.

Q. Okay, counsel hasn't seen any record of that.

A. I'll have to - I'll make inquiries.

Q. Right. Some say now that if they had known the McInroe litigation was ongoing they would have jumped ship.

A. Why?

Q. Because they wanted to litigate the matter.

A. And we then go on a same circle as to if they want to litigate the matter who's going to pay for it?

Q. Legal Aid would have paid for it.

A. Legal Aid?

Q. Leoni McInroe was on Legal Aid.

A. Okay. Well, I've made it very plain that we would not operate on a Legal Aid basis and

they could have done that at that time, you're quite right, they could have jumped ship.

Q. A lot of them say they didn't know that they could have, they just felt it was a take it or leave it, there was talk that you were going bankrupt and they were going to be just left on their own if they didn't take it.

A. I don't believe there was any talk of me going bankrupt because nobody was aware of my personal circumstances and there was no possibility of that happening anyhow.

Q. Just moving to a different topic. Can I confirm that you gave the Police, when you compiled your big complaint, you gave them a copy of Dr Baldwin and Dr Ding's medical opinions?

A. Say that again? With?

Q. You talk about before you start or very early on you get two medical opinions?

A. No, I spoke with two medical experts, I did not obtain written opinions from them.

Q. Did you advise the Police that you'd done that?

A. Yes.

Q. The Police knew that you had -

A. Yes.

Q. - spoken to these two and what they had said?

A. And what they had said, yes.

Q. I'd just like to clarify a little bit more what you say about determining the level of trauma that happened with Sir Rodney's claim. How was that done?

A. Well, it's for Sir Rodney himself to make that decision, but as I described he determined there had to be a weighting on a scale of 1 to 10. So that you would take an individual that had suffered Paraldehyde, the first consideration would be with Paraldehyde say the number of occasions that this individual had experienced it. Now the individual might have said that he had experienced it five times, there may have been medical records which showed that they had in fact suffered it eight, so he would take eight as being the number of times.

Now everybody recovered from the Paraldehyde injections, there didn't seem to be the degree of trauma, of course, that was associated with ECT. So in looking at Paraldehyde, I think he tended to take the number of occasions and then just looking literally across the list of clients, get a weighting or sense of weighting as to how much effect that had had.

There may be some adjustment to his weighting if one individual had a particularly traumatic, perhaps an emotional response to that sort of thing. As regards ECT,

it was very much more a judgmental thing for Sir Rodney because, as I explained, there was evidence of a couple of individuals who, where they saw their friends being subjected to ECT on this regular basis over a long period, were so frantic as to what would happen when their turn came that they undoubtedly suffered in an emotional sense to a higher degree than those who had actually had it. Now that was strictly a matter for Sir Rodney's judgment.

Q. Just have to put one complainant's point of view, is that he was only there for two months, eight weeks, he received ECT I think three, possibly four times, and he was, you know, so he was one of the lower levels of compensation, and yet he lives with horrific consequences of that ECT today. Looking back now, do you think that the way it was done, allocated then, took enough account of the long-term impact on people's ability to earn an income?

A. Looking back with hindsight I think that's right, because there was no account taken of the long-term effect because there was no information. I think if we had inquired at that stage of experts there would probably be no medical literature and long-term effects of Paraldehyde injections in these sort of circumstances. So there was no information before Sir Rodney that he could utilise of that nature.

Q. Right. The final question is just to go back to your actual relationship with these people who signed what is an unusual agreement to take a class action in the circumstances that they did. And some of them say they were lucky to have you there doing that. But I really want to put it to you that it wasn't really a traditional solicitor/client relationship, because they didn't have a one-on-one where they could get legal advice, did they, they were signing up to a negotiation that you would - they had to trust you and what you could get?

A. Yes, that's dead right, but I disagree it was a conventional solicitor/client relationship, they entered into a contract after they'd been given the opportunity to take independent advice. We obtained all the facts from them that we could, any documents that they might have had or any other information, names of witnesses etc, we interviewed all the witnesses, so we got their factual position very, very clear.

We then did a legal analysis, taking into account the extraordinary similarity between all of these clients. We then obtained counsel's view on the position, we then - our letters of engagement, which accompanied the terms of engagement, set out entirely what our job was to do, and.

Initially it was to engage in an alternative dispute resolution mechanism, specifically excluding litigation.

When we got to the point of litigation, new contract now provided for litigation to

be covered. I underwrote the process, they were fully and fairly informed and they had ample opportunity to talk with solicitors in my office and myself throughout the whole affair. Now they did receive advice, legal advice along the way and regular updates as to what was happening.

Q. All right, just two points quickly. With the legal advice, at the end though, it was a take it or leave it situation, and they weren't really advised they could go and join another litigation that was going on?

A. I'm happy to check on that point for the Commission, but I believe they were in that position and perfectly entitled to go somewhere else if they wished to. The offer from the Crown was take it or leave it and everybody had to make their decisions on that basis.

Q. Okay. Thank you.

CHAIR: Thank you. I'm told we have one question from my right.

COMMISSIONER ALOFIVAE: Mr Cameron, I appreciate you've been in that seat for a long time, but thank you, it just goes back please to the very beginning of your evidence.

A. Yes.

Q. Where you describe MSD, Lake Alice and you set out very well for us that relationship. Are you able to talk to that a little bit more?

A. Give me little -

Q. It's paragraph 11 if I could just point you to that. I'm happy to read it to you if you like?

A. Yes, fine.

Q. You say in the early 70s the Department of Social Welfare had responsibility for many State wards and faced housing difficulties for those wards. Apparently when DSW discovered that were some empty dormitories on the grounds of Lake Alice Hospital a decision was made to use these facilities and to start a special unit to cater for these children.

A. Yes, that's right. I think the information here largely came from the report of the Commission inquiry into the case of the Niuean boy and the evidence of Dr Pugmire. I don't recall whether the Palmerston North Hospital Board had to make any, or provide evidence there at the time. But our inquiries certainly came to the very strong, clear position that there'd been this legal demarcation where these dormitories, although situated on that site, were legally responsible and answerable to the Palmerston North Hospital Board and Dr Leeks happened to be the person who was managing it.

Therefore we have to think of this as not being a mental institution in any shape or form. To the best of our knowledge the children who came here, they might have been

emotional disturbed, they might have had some mental disorder in one or two cases, but it had not been diagnosed and they had not been committed, so there was no need for ECT or Paraldehyde in what is essentially just a residence. There is information on our files which show that Dr Leeks went with a staff member to the main hospital and found a disused, or an ECT machine that had fallen into disrepair and that they had brought it back to the unit and fixed it to make it work.

Now that of itself doesn't suggest any remote possibility of genuine medical use, and so I think the division there was quite clear. So a proper exploration of these events and circumstances just reinforced the position we were putting to the Crown and I think we wanted a proper inquiry as soon as we got involved in this case.

Q. Thank you. And were there - because we've heard evidence and we've seen some documentation where Dr Leeks was actually visiting a couple of the local institutions, Hokio, Kohitere and Holdsworth?

A. Oh yes.

Q. Actually going in and assessing for want of - the loose use of that term.

A. I vaguely remember references of him going to other institutions but I know nothing more about that.

Q. Thank you very much Mr Cameron.

CHAIR: Mr Cameron, I've got about 400 questions and I'm not going to ask any of them, because, well, first of time, secondly, we have your comprehensive brief and we know there's more to come. So it just remains for me to thank you very much indeed on behalf of the Commission for the immense amount of work you did, for the burden you carried at personal cost to you, I think, you and your family, and to your law firm. I think it was a remarkable piece of advocacy. I know that some survivors now are not happy with some of the outcomes, but I have to say that to please 95 clients in one step is probably a step too far.

But the other thanks I give you is the enormous amount of documentation and information you've provided to the Commission, which is going to be incredibly valuable in us assessing the rights and wrongs of this whole dreadful business. So thank you for your time and preparation, and thank you for enduring this process all afternoon, and we're very grateful to you.

A. Thank you ma'am.

Q. You're most welcome.

MR MOLLOY: Ma'am we do have one additional witness for the day, I think we need to do her

justice, she's been waiting, but we certainly need to take a break.

CHAIR: We'll take a very short break then and come back and hear from her.

MR MOLLOY: Shall we have 10 minutes ma'am?

CHAIR: Yes.

Adjournment from 4.36 pm to 4.48 pm

CHAIR: Good afternoon Ms Thomas.

MS R THOMAS: Thank you Madam Chair. We now have our next witness, Gloria Barr, and she is supported by her sister this afternoon.

CHAIR: Supported by her sister, hello, what's your name?

SUPPORT PERSON: Marion.

GLORIA BARR

CHAIR: Hello Marion. First of all can I just apologise we've held you far later and that we intended.

A. It's okay.

Q. But I'm afraid it's just the way these things go. I'm sorry if you've had an anxious wait up until now.

A. That's fine.

Q. So we'll get started, do you mind taking the affirmation please. That means I will read it to you and you can agree.

A. Good.

Q. Where shall I take it you thought?

A. Exactly, yes.

Q. Do you solemnly, sincerely and truly declare and affirm that the evidence you give today will be the truth, the whole truth and nothing but the truth?

A. I will.

Q. Thank you.

MS R THOMAS: And Madam Chair, just in terms of the embargo that was directed this morning, if that could be directed for this witness.

CHAIR: Same thing that occurred about the first witness this morning. There'll be an embargo on Ms Barr's evidence until further notice which is likely to be in the morning.

QUESTIONING BY MS R THOMAS: Thank you. Thank you Ms Barr, can you tell us when you first started to work at the Lake Alice Hospital?

A. In 1976 or 77, around about then, that's when I started.

Q. And you were employed as a hospital aide at that time?

A. Yes.
Q. What type of training does a hospital aide require or get before starting?
A. None.
Q. And can you tell us the difference between a hospital aide and a nurse aide?
A. They're the same, one and the same.
Q. And we have got your signed brief, which is fulsome, but for the sake of time we will be highlighting some paragraphs and shifting through some others, so I'd now like you to move on to paragraph 13 of your statement, which talks about the Lake Alice acute villa which was villa 6. How long did you work at that villa?
A. Not very long, I did a few shifts in there, might have been only over a period of weeks, but I didn't do very many shifts in that villa, a few.
Q. I think -
A. A shift being like four days.
Q. Right, four days on and two days off, is that the roster?
A. Four days on and two days off, yes, so a whole shift would be the four days, four days on, yeah.
Q. When you were working at that villa 6, did you ever witness ECT being given to anyone?
A. Yes.
Q. And was that to adults or children and adolescents?
A. Adults.
Q. When it was ECT at that villa, was that in the modified form or the unmodified form?
A. Modified, they had a general anaesthetic just like you would in a surgical operation.
Q. With registered staff, doctors?
A. Yes, anaesthetist, yeah, it looked just like a hospital setting, yeah.
Q. And -
A. Surgical operation.
Q. What was your understanding of the reason for this modified ECT being given to the patients that you observed?
A. It was usually given to people who were either really deeply depressed that they couldn't get out of it, or deep psychosis, and evidently ECT renders them - amnesia, you know, they have temporary amnesia and it seems to help them climb out of their current situation.
Q. And anyone at the Lake Alice Hospital who required modified ECT, what villa would they receive that from your observations?
A. Villa 6, only in villa 6.

Q. Thank you. I'd now like to move on to questions about the Child and Adolescent Unit, this is paragraph 21 of your statement onwards. During your time at the Lake Alice Hospital, so this is either 76 or 77, you were assigned to work at the Lake Alice Child and Adolescent Unit?

A. Yes.

Q. Do you know how many months or how long you worked there?

A. I was there several months. Like it wasn't a year, but I was there quite a few months.

Q. And what was the villa number at that time that you were working there?

A. 7.

Q. And can you tell us a little bit about that villa. Was it for girls and boys, or just for the boys at that time?

A. The villa itself during the day was for girls and boys.

Q. What about the children being free to move, were the doors locked or unlocked?

A. The doors were locked, the doors to the outside, and some internal doors were locked too.

Q. In terms of dormitories, were they upstairs or downstairs in villa 7?

A. They were upstairs.

Q. And what other rooms were upstairs in addition to the dormitories?

A. There was, I think there was two lock-up rooms at the end of each dormitory, the far end of each dormitory, and in between the dormitories, the two separate dormitories, there was a nurses' station. Mostly with glass, you know, you could see right into it, yeah.

Q. You've talked about lock-up rooms. What did they look like?

A. They were just a bare room of about maybe 10 by 12, maybe a wee bit bigger, just solid room with a window with I think it was either shatter proof or had bars on it, I can't remember that, but it just had a mattress in there with a plastic cover, that's all.

Q. So not a bed, just a mattress?

A. No - yes, I mean.

Q. Did you ever see anyone being put in those lock-up rooms?

A. Yes.

Q. What were they put in there for?

A. Might have been if there was a couple of them fighting or one of the kids was sort of losing the plot a bit and, you know, starting to have a, I suppose could be called a tantrum but they weren't tantrums, I mean they would sort of just lose it really, yeah. So they'd be just sort of like time-out but it was time-out in a lock-up room. And it was a safe place too, because there was nothing in there to harm themselves with.

Q. I'd just like to - we've got an infographic or a picture of this villa I'd like to put up on the screen if possible, and just takes a few seconds and then we'll watch that and then I'll ask you some questions. This is villa 7.

A. Yes, it is.

Q. (Infographic played).

A. That upstairs, can I just comment on that?

Q. Yes.

A. Where it's got, it looks like another dormitory in the middle there, I don't ever recall there being a dormitory there, I just recall there being the end ones but not that one there.

Q. So there's three dormitories marked there, but you recall two dormitories?

A. Yes, yeah. And the time-out rooms, lock-up rooms at the end, as drawn, yeah.

Q. Right, so just in terms of the - they were noted as seclusion rooms, there's two of those at each end of each dormitory?

A. Yes.

Q. So a total of four seclusion rooms or lock-up rooms?

A. Upstairs, yeah, there was also a couple downstairs off the day room, I can't remember whether - when you showed that graphic, whether they were on there.

Q. I don't think they came up as a separate room. I'd like to ask you about the - you called it the nurses' station I think just before, where was that?

A. That was upstairs between the two dormitories, a bit like you'd see in an ICU in an ordinary hospital in New Zealand where the nurses can observe critical, you know, patients. And I guess this was for the person who was on night duty there to keep an eye on the dormitories which were in darkness, of course, so unless there was a big hullabaloo, probably things could happen in there that they wouldn't see or know about.

CHAIR: Can I just ask a question here. Ms Barr, we've seen various plans and things, people have drawn hand sketches and the like, and it seems to me, but to confirm, that the plan changes over time, so sometimes it's got dormitories at one end and other things and nurses' stations. Is this representation that we're looking at now, the first floor for example, does that accord with your memory, or is it different from what you remember?

A. It's a little bit different. That - where you can see the dormitory in the middle there.

Q. Yes.

A. I don't recall there being a dormitory there.

Q. Yes.

A. I'm not quite sure what rooms were there. Unless the nurses' station was back further than

on this drawing, because there was quite a largish area, floor area between the nurses' station and where the bathroom is. I certainly recall that bathroom, yeah, because I used to supervise -

Q. So where on that would the nurses' station be, according to your memory?

A. Where it says dressing room, that would be there. Now if there was - yes, look I sort of can't comment any further, I'd only be speculating.

QUESTIONING BY MS R THOMAS CONTINUED: In terms of that nursing station in between the two dormitories that you remember, the left and the right winged dormitories, if that nurses' station was based where it says "dressing room", did you describe that as a room, a glass room like a watchhouse effectively for the night nurse?

A. There was glass above the desk height, you know, sort of sit around like this and there was glass.

Q. How many nurses were rostered to be on nightshift?

A. I only ever knew of one being on, one registered staff.

Q. Okay.

A. Yeah.

Q. And they would be based in that room?

A. Yes.

Q. Thank you.

A. That was once everybody was in bed, yeah.

Q. I'll ask for that to come off thank you. I'd like to ask you some questions about the school at Lake Alice that you saw when you were there. So this is in sort of 76 or 77. I understand you went to the school with some of the adolescents, you escorted them there to effectively help if need be in the school room?

A. Yes, I did. Myself and a couple of other hospital aids or nurse aides. We were in civvies too, we didn't wear our nurse's uniforms to make it - so it made it look less institutionalised.

Q. What was your impression of the school and the teachers in that room?

A. I thought the school was very good, it was just an ordinary pre-fab that had obviously just been put there, but the teachers, particularly the one in particular, and I sort of have said to you I think her name was Sarah or something like that, but she was lovely and she was one of those rare, not rare, there's probably a few, but those teachers who have good command over their class and everyone respects them and everybody listens and nobody plays up and nobody did play up in those rooms. I never ever recall her having to stop proceedings to deal with anybody, you know. Everyone just - it seemed very peaceful actually.

Q. Did all of the children from the unit get to go to school or did some of them stay back at the unit?

A. Most of them got to go to school. It was only if they had been playing up or they had to stay back just for a doctor's appointment or for any reason like that but otherwise they went to school.

Q. Was school for a whole day or half a day?

A. No, it was just for the morning, yeah. I'm just - actually I'm not quite sure whether it was even the whole morning, because I can't visualise stopping off to have morning tea or anything like that, maybe they did, but I can't - that doesn't stick in my mind. But they may have been there from 9:30 until 11:30 or something like that, yeah.

Q. I'm going to ask you some questions now we've moved on to paragraph 27 of your statement, about other staff that worked at the unit when you worked there. I think you've mentioned you recall a nurse aide called Denis?

A. Yeah.

Q. And what was he like, what's your memory of him?

A. Denis Hesseltine was a lovely man, he was just a very lovely man, yeah, very pleasant, very kind to the kids, and he was almost a bit of a mentor in lots of ways, yeah.

Q. In that paragraph you've gone on to note that the atmosphere in general at the unit could often be hostile and confrontational. Can you tell us a bit more about that, why was the atmosphere hostile?

A. It could be because if you could imagine a whole group of young people of those ages, I mean just in a normal family if you had children fighting and squabbling over things and it was no different there. And I think a lot of them were perhaps tired or stressed and all of those things, and so there would be conflict, and of course, you know, some would be egging others on and, yeah, it was just, just as I say, yeah, they would - there would be fights, the odd fights break out and, you know, a kid having a meltdown and so it went on, yeah.

Q. Paragraph 29 of your statement you talk about the charge nurse, Dempsey Corkran?

A. Mmm-hmm.

Q. Can you tell us a little bit about him, what was your impression of him?

A. He always seemed to me quite detached, he was very serious, and he just went about his business but he wasn't - he wasn't sort of really a kindly sort of person, it was sort of just - he was quite austere really and just did what he had to do without any frills type of thing, yeah.

Q. And then at paragraph 30 there's another staff member you've mentioned the name of Howard Lawrence?

A. Yes, Howard just worked the nightshift.

Q. So did you work with him yourself?

A. Only on cross-overs. Meaning when we were - the ones who were working until 8 o'clock at night were knocking off and obviously there had to be a period of cross-over, and the registered staff would, you know, maybe give any information they needed to to the person coming on nightshift, and - but as far as I was concerned I didn't really need to have any interaction with him, I just observed him and he was there and he pretty much ignored the likes of me. I was inconsequential.

Q. Right. So he would always work nightshift was your memory?

A. Yes.

Q. Of that time.

A. Yeah.

Q. And did you ever observe his manner with the adolescents at all, how he interacted with those children?

A. What he really wanted to do was get them all to be into bed as quickly as possible, there was no niceties and no dilly dallying, it was once he was there, he just wanted them all upstairs and in bed.

Q. Moving on to paragraph 32 of your statement you talk about the psychologist Victor Soeterik?

A. Mmm-hmm.

Q. Can you tell us what you remember about him and the group therapy sessions?

A. Yes, well, he - group therapy sessions were run a couple of times a week by, what I recall, and he was the one who mainly ran them. I was only ever present in a few times the whole time I was there, and it seemed - do you want me to say a little bit more?

Q. What were the purpose of these sessions as you understood them?

A. Well, obviously they were there for - maybe not obviously, but they were there for therapy, I would have thought, but to me they always seemed like places where each - children could dob each other in, you know, point the blame at others and then, you know, several would wade into, you know, agreeing with them or whatever, and, yeah, to me it didn't seem very therapeutic, in fact they seemed counter-productive to what the whole aim was, yeah, I didn't see them as very useful at all. I would have thought if there was any therapy going to be done in that way it would have been done one-on-one, would have been a lot

more respectful, yeah.

Q. What did you think about these teenagers or these adolescents being brought together into this one space in general?

A. It seemed to me, it was a most unnatural situation for a whole group of children to be in, because there were - there weren't any loving adults there, you know, apart from probably myself and Denis and Sandra, but - and maybe one or two others, but, you know, I know, I observed them being very kindly with the kids and I know I certainly did my best, but having had - having three boys myself at that time, and they were around about nine or ten years, eight and five years old, I couldn't imagine my children having to be in this sort of situation with very tense, very stressful and not very loving, you know. I used to think some of these kids just need a big hug from a mum and loving mum and just be told they were okay, you know, they're okay.

Q. You mentioned that at these group therapy sessions the kids would sometimes dob each other in. If that happened, did you observe any consequences for that type of - if a child said "so and so did this", what would happen?

A. Well, I did observe consequences, whether they were specifically for what transpired in the group therapy sessions, I mean they could quite possibly have been. There were probably quite a few complex situations going on all the time, and - but I certainly observed children being punished in ways that were really, in my view, not appropriate and not very nice.

Q. Just in terms of the punishment, in your brief at paragraph 34 you've said that patients who complained would get a further dose of punishment veiled as treatment. What do you mean by "veiled as treatment"?

A. Well, unmodified ECT, the word ECT is electroconvulsive therapy, you know, it's therapy, meant to be therapeutic. But of course it was anything but there, and you know, the children, the kids knew that and they would talk amongst themselves, you know, and they were pretty fearful most of the time, a lot of the time actually, of that or having a Paraldehyde injection. And they were hideous, because, you know, apart from it zonking the child out for goodness knows how many hours, it might have been 24 hours or more, but then when they were wandering around they were like zombies, literally like zombies and a horrendous smell was emanating from them because of this Paraldehyde, it was really hideous, yeah, it was terrible. I, you know, I just used to - it was not good.

Q. Can you tell us your memory of Dr Leeks, what was your impression of him when you were working at the unit?

A. He was cold and detached. For the people like myself, he really pretty much ignored me,

you know, because I didn't - I wasn't part of the, you know, of the therapies, the "therapies" that he did there in the main, you know, I was just there. But yeah, he wasn't that - he wasn't very friendly, that's for sure, yeah. He was just detached.

Q. You've talked about children receiving punishment or unmodified ECT as punishment. Can you recall a particular occasion where you observed this happening?

A. Yes. I was actually on duty one day and I had observed on other occasions children being taken upstairs and by what other kids there were saying, they knew they were being taken up to have ECT to be given ECT. But anyway, on one occasion I was asked to come too, and so I went up, and it sort of turned out that they had to have several people there because the child who was having ECT was having it unmodified and not been given a muscle relaxant either so the jolt could actually dislocate their shoulders, their hips, their knees, their ankles, and so people needed to hold on to those joints of the body when the ECT was administered, and - which was by two things on the side of the head, and the child was awake, so okay, this is what I saw this day, a young boy called GRO-B, I can't think of his other name, and he was absolutely petrified, he was just absolutely petrified and of course he got zapped in the head and then he starts shuddering and, you know, it was pretty nasty.

Q. Before this boy was taken upstairs for this ECT, what had happened to him just prior to this?

A. He had soiled his pants, he was probably about 13, 12, 13, I think he was about 13 years old, he had soiled himself and I think he had done that on previous occasions, but this time he'd soiled himself and so he was being given unmodified ECT for soiling himself. I don't quite make the connection myself as to how that's going to fix it, but I did - I used to think that - you haven't asked me this question yet, but I was just going to say about me thinking that Dr Leeks and Vic Soeterik and even registered psychiatric staff had had training in these things and they must know what they're doing, and even though it looked hideous to me some of these sort of behaviours, but maybe they were bona fide treatment methods, you know, but I wasn't - yeah, that's - so it was a bit, you know, it was very uncomfortable.

Q. So you weren't trained in this, but you were following what you believed was - these people were trained, the psychiatrist, the registered nurses, this is what you were led to be was acceptable?

A. Yes, yeah. I don't know whether it was actually voiced in that way, but that was the assumption, you know, they're trained doctors and trained nurses, we trust them, they should know what they're doing, they should be doing things that are correct and right,

mmm.

Q. I'm just going to ask for a document to be put up on the screen now which is ending 00774. Just to orientate you to this document, Ms Barr, this is a document that comes from the Police investigation in 1977, and at that time the Detective Butler was speaking to Dr Leeks about a person at the unit who was at the unit in 1973. So I'll just read this into the record, so Leeks says:

"The pet referred to is actually - redacted - had a brief course of Aversion Therapy. He was quite a soiler of his trousers and nothing seemed to stop this and I think after one or two sessions of this of about half a minute he stopped soiling." Then Detective Butler says "Note reference - redacted - aged nine years admitted 73 discharged 73."

So that is a document that refers to a child and adolescent patient in the unit in 73 who also received, in Dr Leeks' words there, Aversion Therapy for soiling his pants and you've just told us that this was still ongoing when you were in the unit?

A. It must have been, because I see this boy was nine years old, my God. Yes, he must have been using the same treatment.

Q. Or technique.

A. Sorry, or non-treatment, yes, technique, the same, yeah, he did the same thing.

Q. Thank you, just moving on to paragraph 42 of your statement, I'll just actually ask you to read that paragraph out to the Commissioners.

A. It was common knowledge among the staff in the unit that ECT was given as punishment. The kids knew this as well. Whenever a patient was taken upstairs the rest knew what was going to happen. It was awful.

Q. In terms of your opinion that it was common knowledge, how was it common knowledge, how did the staff know what was going on?

A. You couldn't help but know, because all the registered staff were involved in it, and us hospital aids or nurse aides there were - if we weren't personally involved doing what I did, and some of them probably had done it as well, you know, had to assist with holding joints if there weren't enough registered staff around, then you would know that a child had been taken upstairs, and several people had gone and that was the reason why somebody got taken upstairs. And of course this wasn't done in any sort of a hospital room or a clinical setting, it was done in the dormitory on one of the beds, just in the dormitory, yeah.

Q. In terms of Paraldehyde you've said in your statement that that was also given as a punishment. What makes you say that?

A. Because of the effects, well, talk about the effects first, the effects on the person who's had

the Paraldehyde were horrific, they were terrible. It's not - and it was the times in which they were administered. I mean normally if you've been prescribed something for a particular condition there's certain protocols around when you have that done and so on. You'd be in the clinic and so on, but these could be administered in the hallway or anywhere, you know, and that's where I observed one particular day, you know, a kid got a jab in the arm, it was in his arm, you know, and he had - yeah, that's what happened there. So it was common knowledge.

Q. I'm going to ask you a question about your - at paragraph 47 of your statement you've said "I never thought these teenagers were treated respectfully." What makes you say that?

A. The way they were handled and spoken to sometimes by the registered staff and often the registered staff, unless they were doing specific things for them, you know, to do with clinical sort of stuff and maybe the group therapy sessions or something like that, sometimes they wouldn't be around so much, you know. Sorry, what was that question again?

Q. It was just around whether these patients or these teenagers were treated with respect at the unit.

A. Right, okay. So just the fact that there was very little kindness shown that I could see, and they were sort of, you know, all lumped together and, you know, had herded into meal times together, even bath and shower times. Shower times, for example, I think teenage boys particularly, you know, should be showering in private, but they would be just in the main bathroom as well, of course I or any other staff are in there. And I thought actually this is not really very respectful of these people. And bearing in mind this is only the boys because the girls slept in villa 6, they didn't sleep in villa 7.

Q. And during the day the girls came into villa 7?

A. During the day the girls came from villa 7 but they went into villa 6 after tea. So it was just the general way they were treated, and it didn't seem as if anybody was advocating for them. I mean I can't say I ever saw any parents, and I know quite a few of these kids were foster children and from other homes-type situations, institution-type situations, but there was never relatives or parents or people coming to visit them, nice things happening.

Q. In terms of what you've told us about the ECT that you observed, or the unmodified ECT as a punishment, or Paraldehyde as a punishment, were you ever in a position, were you ever able to raise this or complain to anyone what you had seen?

A. I wasn't in a position because I didn't have any knowledge of any process to follow, and bearing in mind that I was sort of thinking, you know, these are trained people, Dr Leeks

and the psychologist and the staff, as I said before, maybe this is okay, but it doesn't look okay to me. But at the hospital I just knew, if I said anything to anybody they would close ranks. There was nobody I could identify at that hospital who I could say I didn't think this was right, yeah.

And in retrospect or in hindsight, if that happened with me today, I would probably go to a human rights lawyer or somebody like that. I wouldn't do it within the institution itself, I'd go out, yeah, and then put somebody between me and the institution sort of thing, yeah. But I would complain if it happened nowadays, I definitely would.

Q. With the benefit of hindsight?

A. With the benefit of hindsight, absolutely, I would advocate, I would stick my neck out, yeah.

Q. Was there any an occasion where you did say something to the charge nurse, Mr Dempsey at some point in relation to one matter?

A. There was actually, there was this woman that started working there at exactly the same time as me, she was a sort of friend of mine, a sort of friend, she wasn't, you know. Anyway, she worked in the adolescent unit quite often too, and one day she had arranged for, I think there was two or three, no more than two, two or three of the teenage boys were going on town leave into Marton, and she had invited them around to her house, so she had these boys at her house, and she told me that this had happened, she said they'd come, you know, she'd had them around. I have no idea what they did there or whatever, whether they had lunch, I have no idea. But the very fact they went to her house rang real alarm bells with me, I thought no, that can't be right, you're not meant to have the patients, take them home with you to your own home.

But I was now in receipt of this information, I thought well, I can either say nothing to anybody, or I can at least tell Dempsey Corkran, who was in charge of villa 7, so that at least he's aware that that happened. And so that's exactly what I did, I went and hold Dempsey and he listened to me and he sort of acknowledged what I'd told him, and that was that and I never heard anymore about it.

So I have no idea whether he chastised GRO-B, this lady's name was GRO-B , the nurse, or whether anything at all happened. But in my mind I thought if somebody finds out, and sure as eggs somebody would find out, somebody would know and it would get back to Dempsey, GRO-B could have then said to Dempsey "Well Gloria knew", and then I would have been in the gun because, you know, he then might have said to me "Well, you

knew, why didn't you tell me?" Yeah, so I did, I had to, I did tell him.

Q. So you told him but you didn't observe anything change per se?

A. No, I didn't observe anything. GRO-B, I think GRO-B carried on working there and no, I never observed, nothing more happened about that, yeah.

Q. If I could just ask you to move to your final sentence at paragraph 51 of your statement and just read that out to the Commissioners.

A. Okay. I believe it is important former staff members of the adolescent unit speak out about what they witnessed there as it was not right.

Q. Thank you. If you could just remain there and answer any questions if the Commissioners have any.

A. Okay.

CHAIR: Just a quick question from me. You describe some of the children being terrified about these ECT, that "it was an atmosphere that wasn't very respectful and I get a feeling of tension and not a very pleasant place to be for the children", is that right?

A. Yes.

Q. And it also seems to me it wasn't a very pleasant place for staff either, would that be right?

A. No, well, it wasn't in lots of ways. I think, I know people like myself would be trying to compensate and I would just be kindly, just chat with the kids and give a little bit of kindness to them because they didn't get much of that. But generally no, it wasn't, it was quite shocking really. The fact that I had three sons myself, I would often think back, I couldn't bear any of this happening to my boys, it was pretty horrible, it was pretty horrible. And I actually - I wrote my - I've written my memoirs, I haven't told you this, but I've written a book about my life and there is a chapter in there about Lake Alice Hospital, and actually that's the chapter that Mike Wesley-Smith got in the beginning.

Q. So that was the trigger for -

A. That was the trigger, yes, because a lot of these things, you know, stayed in my mind that a lot of these happenings they never leave you.

Q. Yes.

A. They're vivid, they're vivid things and just the boy that had ECT that day, his name was GRO-B, he was like a frightened rabbit, the look in his eyes, you can imagine all these adults around him holding him, Dr Leeks is there with the ECT machine, they put the electrodes on his head, you know, and he's going to get zapped. I mean how would you feel like if that happened to you unmodified? It is torture, it is severe abuse, not okay in

anyone's language. I wish I had done something about it more then, but I really didn't know who to go to, yeah.

Q. Well, you're doing something now. I'm going to hand you over to my colleague, Commissioner Alofivae.

A. Okay.

COMMISSIONER ALOFIVAE: Gloria thank you, all the questions have been asked and I really just - we're indebted to you, we're grateful for your patience in waiting very kindly to the end of the day to give your evidence.

A. That's okay.

Q. We've heard it said before off and that once you see something you can't unsee it.

A. That's right.

Q. So we're very grateful to you to you for your recall and how you've placed your evidence before the court. Thank you also to your team, Marion, your sister, your counsel, Mr Caldwell, thank you for coming in support and of course to our well-being person who's right here to be able to offer you support. So thank you for formally putting this on the record for us.

A. It's okay, I'm happy to do so, yeah.

CHAIR: Many thanks. That brings our proceedings for the day to an end. We do have a kaikarakia. Mr Molloy?

MR MOLLOY: No, indeed ma'am, I was just going to confirm that.

CHAIR: You were just standing up to say (inaudible). Kei a koe e pa.

Hearing closes with waiata and karakia mutunga by Ngāti Whātua Ōrākei

Hearing adjourned at 5.31 pm to Tuesday, 22 June 2021 at 10 am.