ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
DISABILITY, DEAF AND MENTAL HEALTH INSTITUTION 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) Paul Gibson Julia Steenson
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton QC, Ms Ruth Thomas, Ms Lucy Leadbetter, Mr Michael Thomas and Ms Kathy Basire for the Royal Commission Mr Gregor Allan, Ms Sandra Moore and Mr Vaughan Dodd for the Crown
Venue:	Level 2 Abuse in Care Royal Commission of Inquiry 414 Khyber Pass Road AUCKLAND
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Adjournment from 3.24 pm to 3.47 pm

COMMISSIONER GIBSON: Thank you, Mr Thomas.

MR THOMAS: Thank you, Commissioners. So, we have Sheree Briggs here to give evidence. Madam Chair or Commissioner Gibson, did you want to take the affirmation.

CHAIR: I'll do the affirmation.

Good afternoon, thank you for coming and I appreciate you've had a difficult journey up here, weather and aeroplanes permitting, so we're grateful for the effort you've made, and very pleased to see you in person. Can I just get you to take the affirmation please.

SHEREE BRIGGS (Affirmed)

MR THOMAS: Just by way of introduction, Sheree's here to give evidence about her time as a psychopaedic training officer at Māngere Hospital in the 1980s. She's happy to take questions during her evidence.

Sheree, we can just start right in if you like. I guess, firstly, can you tell us like a bit about your background and professional training?

CHAIR: Sorry, before you do, are you going to show the video?

MR THOMAS: Oh, beg your pardon. Thank you for the reminder, Madam Chair. We've got a short video scene setting to play for Māngere, one minute. **[Video played].** Thank you, Madam Chair.

QUESTIONING BY MR THOMAS CONTINUED: Sheree, I'll try that again. If I could just get you to start with telling us about your background, professional background.

A. Sure. I worked at Māngere from 1979 to about 1984 and prior to that I had worked for

IDEA Services, which was then known as IHC, doing part-time residential care work when I heard about Māngere and the opportunity to do training as a psychopaedic training officer, so I made a pathway to that over a few years and started there, yeah, in '79 and completed the training a training officer over that time.

Q. How long did that training take?

A. About three and a half years, yeah.

Q. That was on-the-job training, as I understand?

A. Yes, yeah.

Q. Working at Māngere?

A. Yes, yeah.

Q. This is jumping ahead a bit, but you later did some further training?

A. Yes, after I left there and went away overseas and worked, went over to Australia worked in similar -type settings over there, I came back to New Zealand and they had started the deinstitutionalisation process, and the Māngere clients were being transferred into community settings, into -- under Spectrum Care, so I worked for them for a while, and then while I was also training doing -- well, wasn't training, studying, doing an undergrad and then postgrad in psychology, and then once I'd finished and trained as a psychologist I continued to work for Spectrum Care until 2007 and then I left and worked for another organisation with children with autism.

Q. Thank you. Can you describe what the sort of a- little bit about what the -on-the-job- training was like as a psychopaedic training officer at Māngere?

A. It was a mixture of working alongside other trained training officers and some theoretical work that you had to do and classes that you did on site, and then a period of six months we went down to Kimberley Hospital and stayed in Levin and did six months theoretical and practical training, but mostly theoretical. Mostly around sort of it- was a medical model, so there was some parallels with the psychopaedic nurses but it was also a large component of what was then called behaviour modification. So, a lot around learning -the around-- different types of teaching techniques, prompting, reinforcing, reductive techniques.

Q. Thank you. We'll come to talk about some of those techniques in more detail shortly, particularly the aversive therapy.

I guess, can you just tell us when you started at Māngere, I guess a bit about what it was like at that institution, just to give everyone an idea of, I guess, the size of it, how many

residents, how it was laid out?

A. I think it was physically-- it was about 10 or so acres on the main site. There was another site in Papatoetoe that was in an old orphanage, I think, and there was a large workshop there for more capable and older people who could do some manual work, and I worked there for a little while, but I mainly worked at Māngere. And then in the middle of the sort of grounds was a training centre and it had classrooms and other facilities in there and people from the units, they were called some- of them came up for training and some people from outside came into- the training centre as well.

There would have been about, I think about 13 units or so on site and there was one other one, a smaller one in a residential house around the corner with about 600 people living there, I think.

CHAIR: Do you mind if I ask a clarification question. We're using the word training in about three different ways here. So, you were training to be a training officer?

A. Yes.

Q. And so how many people were at Māngere when you were doing that, how many people were in your situation?

A. Psychopaedic training officers? That's a good question. Probably 15 to 20.

Q. Quite a number.

A. Yeah, yeah.

Q. That's one sort of training?

A. Mmm-hmm.

Q. Then you went off and you did your own training --

A. Yes, yeah.

Q. -- which was to become a psychologist?

A. Yes.

Q. Then you're talking about a place in Māngere at the centre where --

A. Where children came, yeah.

Q. Who are you talking about coming to training at that? Are you talking about the residents or are you talking about the people training to be training officers?

A. So, the children came there, and they were taught, so we taught the children.

Q. Shall we say teaching the children?

A. Yeah.

Q. Would that be helpful just to get rid of this train wreck-- of training?

A. Sure, yeah. We were kind of schooled not to use that because we weren't teachers, we weren't under the teaching profession, we were a qualification alongside the psychopaedic nurses that were specifically for those children who lived in the institution, so we couldn't teach or work outside of the institution.

Q. So "training" is the right word really, I don't want you to change your evidence, but just so we're quite clear about all of that.

A. Yeah.

Q. Now we understand. So, what you've just been talking about in the centre there, training places where residents, children came to be trained?

A. Yes, in the main training centre they were children, predominantly children, and there was another little building next to that that had older people, and then the more, the more senior and more capable were in Papatoetoe.

Q. Thank you.

Sorry to interrupt, Mr Thomas. I think I certainly understand it a bit better now, thank you.

QUESTIONING BY MR THOMAS CONTINUED: Not a problem, Madam Chair. At risk of further confusing the matter, I'll ask: How many trainers were training the training officers, if you like, would you say?

A. So, there were none, none specifically, so it was like a mentoring type programme, really. You worked alongside another training officer for a period of time in their classroom with children in their classroom, and you did kind of a little rotation and then you, I think it would have only been three months after I started there I had my own class, and in the class was me and about five or six children and then one or two nurses who worked in the units where the children came from also came up with the children and worked in the classroom with us, because the children weren't in the units anymore, so they came up with them.

But there was only there-- were three training officers who taught us that were based at Kimberley, and that's all they did. They didn't work with children.

Q. Thank you.

I won't ask any more questions along those lines, Madam Chair.

And I guess from this point forward we'll be mainly talking about the training centre and the children attending that, or largely children.

A. Mmm-hmm.

Q. I guess on that, yeah, can you you've-- already given us a pretty good description of

Māngere. The training centre itself, like how many residents were attending that?

A. 30 or 40 out of the 600 or so. So, they were only seven or eight classes, small, and they only had five or six children in each class, so, yeah, not many, considering how many people lived at Māngere.

Q. I guess, what opportunities were there for the remaining residents that weren't attending the training centre?

A. None.

Q. In your statement you talk about children arriving and families bringing their children to Māngere. Do you want to discuss that briefly?

A. Yeah, I became more aware of that when I left Māngere and started working for Spectrum Care because there were some reconnection with families there, so I heard the stories about that once a child was diagnosed with a disability, in particular one parent I talked to, she had twins that at around 18 months, two years, it became very evident that they had quite a significant disability, and she took them to Māngere and was advised to place them there and to move forward and have more children or do something else, and forget that she'd had these other children, and she didn't come and see them, I think perhaps three or four times came out to Māngere and saw them and found it so distressing that she never went back, so she didn't reconnect with her two sons until they were in their 30s and in residential care, in the community, and that was common.

Q. I was going to ask, was that a typical scenario?

A. Yeah.

Q. So, were family visits and connections encouraged or discouraged?

A. No, well, yeah, I don't know if they were discouraged, but they weren't they- didn't occur very- -- with any frequency and we certainly never saw any parents at the training centre where the children were being taught, yeah, only the ones who came in for day stays, but otherwise I didn't meet any of the parents.

Q. What about if someone did come, was there anywhere they could go to meet their child?

A. No, that was one of the things that this parent in particular talked about being a problem, she just had to put them in the car and then drive them around and then drop them back again.

Q. Sure.

A. Yeah, and she found that quite problematic, and a not very valuing visit.

Q. Can we move to talk about I guess day-to-day- life and care -- sorry, I have just been asked

if you could move that mic a little bit closer to you.

Sorry, I was just going to ask, can you describe a bit more about what it was like, I guess, day-to-day life in Māngere and, yeah, the residential unit?

A. When I first went for a job interview there, or like an orientation visit, we went around all of the units and were shown and met people who lived in there, and I was told afterwards it was a bit of a, like an exercise to see if you could stick it and if you had the ability to sort of cope with that, then you could work there. It was I'd-- never seen anything like it before in my life, and they took you to the units where the most disabled people, physically and intellectually, were living and it was barren, there were people crawling on the floor, there was one person who had a stand-up frame to walk in but he wasn't placed in it and so he was sort of bottom shuffling, pulling it along. There was nothing in there, it was just a vinyl floor and high windows.

And then we went to another unit where there were more mobile people who were older, bigger males and there was a lot of aggression between them while we were there. Yeah, it was quite confronting and quiet, yeah, it wasn't there-- wasn't anything for them to do, yeah.

Q. Was that sort of like an orientation, if you like, for you, like to the --

A. There were three of us, two didn't come back, mmm.

COMMISSIONER STEENSON: Can I just ask a question. So, do you think that the things that were going on there was the reason why they discouraged family and parents not to visit and not have contact? Or was there another reason that they --

A. Possibly. I think possibly that and possibly an ideological or philosophical sort of pervasiveness of the time was that if you had a child with a disability it went into an institution and you got on with your life, so I think that had a role to play.

But yeah, I didn't ever see any parents in the units and when they took their children out, they took them out in the car, so they didn't stay in the day room with them or spend any time in the homes that they or-- in the places they lived.

Q. Thank you.

QUESTIONING BY MR THOMAS CONTINUED: How were the units or residents living in these units, were they grouped together by level of disability, or how did that work?

A. There was a couple of units that were gender, so one unit, unit 3, had females only who were mobile and capable. And yeah, I could go through them one by one, but there were some that were people with high physical disabilities, you know, extreme physical

disabilities and high medical needs. There was another one there -- were a couple of males only, there was one that was for smaller children, yeah, up to eight or nine. So, they were kind of grouped for different reasons, but the ones that came to the training centre to be taught came from specific units only.

Q. And what were they, just to help us understand?

A. The one that had children that were under eight, the one, unit 3 with the females that were more capable, and there was also a classroom that had people with mainly physical disabilities, so they came from one of those units.

Q. How young were the children in the youngest ward, if you like, sorry youngest unit?

A. Three to four was the youngest, three to four years old, but they didn't come to the school until they were five.

Q. If it's possible to, can you describe the staff and resident relationship at Māngere?

A. It varied. I mentioned that I felt the staff that were working at the training centre demonstrated more compassion and care for the wellbeing of the people that they were working with. There were some, definitely some - nurses as well that were good sorts and there was a whole bunch of nurses and nurse aides that weren't and did not demonstrate they-- were cruel and unkind.

Q. Was there an overall sort of ethos amongst the staff or was that only with some staff?

A. It was more it- was -more there-- were more staff that were unkind and cruel than there were that were nice.

Q. Can you tell us about, I guess, the difference in activities for residents attending the training centre versus those that were not, I think you've already touched on it but...

A. Mmm. So, for the children that came into the training centre, we had a curriculum that we assessed them against to see where their skills were and then identified specific skills to be taught and use the techniques that we were learning to teach those. They also had some time outside in the playground area, and day trips out, as well, and the people who lived in the units didn't. So, they went for walks around the grounds occasionally up to there- was a gym that was based on the top of the hill,- and they sometimes went in there. There was a pool that some people got to go in. But in the units, there was no programmed activity or equipment or, yes, any recreational toys or objects or anything.

Q. The residents that were attending the training centre, how often would they be attending, every day?

A. Yeah, Monday to Friday they went back to the units for lunch and then came back after

lunch and had an afternoon session.

Q. Would it be fair to say, then, there were a lot more opportunities for those residents than anyone else?

A. Mmm, yeah, we took them once- a year we took them camping to Kauaeranga Valley and we also took them out to the Beach House, which is a house out at Maraetai- that I think was under a family trust I think for people to go to.

Q. I am going to move on to ask you about aversion therapy and different aversion techniques that you witnessed at Māngere.

A. Mmm-hmm.

Q. Before I get into the specific techniques, I understand you're aware from your professional training that the Commission has heard some evidence from a Dr Parsonson about aversion therapy and minimum requirements, if you like, for a practice to be regarded as aversion therapy, such as an appropriately qualified therapist, an assessment process to determine whether a certain behaviour is sufficient to justify an aversive therapy. I guess, can you tell us whether those requirements or minimum standards, if you like, were applied then at Māngere?

A. I know they most likely are applied now but they weren't applied when I was working at Māngere, there was no there- was no looking at the least restrictive alternative in terms of if a behaviour was identified as problematic, then punishment was a quick and effective technique that was suggested to reduce problematic behaviour. And the training would be: This is how you do it, rather than this is why- it's needed or what else, you know, what's the procedures for the withdrawal of the punishment, what are the procedures for, you know, what alternative approaches could we consider, what alternative behaviour are we going to teach to meet that same need, looking at why they're doing what they're doing.

There was not it- -was that's-- the difference between science now and the science then, it was behaviour modification which was to increase or decrease with whatever techniques you had rather than looking at analysing why behaviour is occurring.

Q. Thank you. I guess, would you need any sort of sign off from anyone to apply Aversive Therapy or technique?

A. Not then, no. There was one situation where a wee girl that was in my class left the premise, left the facility quite frequently, and left the unit on one occasion and ended up in the mangroves behind her unit and it was proposed that we use electric shock therapy to -- electric shock to -- contingent on her crossing a line, which was determined as the

front doors of the training centre, and I was to be delivering that, monitoring her and setting the situation up so that it could happen, and then use the remote to deliver the shock.

Q. And did you?

A. No, no.

Q. What was the how-- was the shock to be administered?

A. She was wearing, the belt, she wasn't wearing it, but I was shown a belt that she would be wearing around her waist.

Q. I guess, did you witness that happening?

A. No, it wasn't implemented because she was in my class and --

Q. What happened when you refused to administer that?

A. We came up with some other techniques that were less aversive, yeah, mostly close supervision and then we also moved her into a different class where there were less children and it was more of a play-based class, mmm.

Q. Thank you. At paragraph 2.11 of your statement there's some different aversive practices that you mention, and I'm just going to take a little bit of time to ask you about each of these.

You've just mentioned an example of electric shocks. Perhaps the next one, ammonia capsules; do you have any examples that you can recall of that being used?

A. For self-injurious behaviours. They were snapped under a person's nose for aggression towards others.

Q. Sorry, just to go back one step, just to clarify on the shock belt that you mentioned , it was the case that you didn't see that being used --

A. No, no.

Q. -- by any other staff?

A. No.

Q. Thank you. What about, how was medication used?

A. As a restraint, as a chemical restraint, there were also medication trials that occurred where a researcher asked for participants in different medications and we were taking data on, blindly, on effects of that medication, but there's a lot of, well, yeah , a typical psychotic medication, you know, that's not used now but was used then that were quite, I suppose frequently and overly administered and prescribed.

Q. Are you thinking of a particular medication?

A. Haloperidol was one that was used a lot, Risperidone and the other sort of less dirty

anti-psychotics weren't available then, so there was a very, just medication that was used for behaviour rather than any mental unwellness.

Q. Did you observe were-- there any adverse effects of Haloperidol for example?

A. Yeah, tardive dyskinesia.

Q. Did you see that happening?

A. Yeah.

Q. What about other medications like Paraldehyde?

A. Yeah.

Q. How was that used?

A. Injected, yeah. I didn't see, that but I knew of it.

Q. In what sort of situations might that be used?

A. For escalations of behaviour. So, if, particularly at St John's, if a person's behaviour escalated there was minimal staff available there and they were taken back to their residential place and, yeah, we'd find out what had happened.

Q. And was the medication administered back at the residential unit?

A. Yeah, we didn't administer any, that was the nurse, yeah, that was the nurse's role.

Q. Was there anything else on medication you wanted to mention?

A. Well, it was overused and not reviewed frequently, and not removed if it was causing other problems.

Q. Was it used as a form of control?

A. Mmm, mmm, yeah.

CHAIR: Before we leave medication, do you mind if I just ask a question about this. You refer to research trials.

A. Mmm.

Q. Who conducted those?

A. Am I allowed to name who?

Q. I'll just check. When I say who, did they come from within Māngere or were they from an external organisation?

A. An external researcher who approached Māngere and the psychiatrists, I suppose, at Māngere and the paediatricians to identify participants.

Q. We'll just leave at that: An external researcher came in, with the permis sion of the Superintendent or medical officers, and conducted the research?

A. Mmm-hmm.

Q. Was there any question of any consent being given by the parents of these children?

A. Or the people who were giving getting-- the medication, some of them were adults.

Q. The first one is the parents.

A. Yeah no.--

Q. And secondly the I- mean, it could be either, I'm not doing it in order of priority but -just what-- about the children or the people receiving this research?

A. Not that I was aware of.

Q. Were you aware of any protocols that surrounded that research?

A. Only the procedures that we were given on how to record the behaviour, nothing else. We weren't giving the medications, but we were doing the recording.

Q. You were asked to record the behaviours after the medication was given?

A. Yeah.

Q. Who administered the medication?

A. The nursing staff.

Q. At the direction of the researcher?

A. Yeah.

Q. And did this go on all the time or was it just occasionally or how often?

A. There were at least three trials that I can recall during the four years, three and a half years I was there.

Q. And you and your colleagues would write up the results, would write up your observations, give that back to the researcher?

A. Yeah, it was quantitative data so there were specific things they were looking for. So, there might be side-effects, ticks or some specific behaviours -or and-- they were predominantly around addressing behaviours of concern, so the people that were identified as participants were people that had been identified as having some problematic behaviour. So, they were --

Q. So they were being tested out to see if whatever they were given was --

A. Yeah.

Q. -- made a difference?

A. Yes.

Q. Do you have any idea what the drugs were that were being trialled on these people?

A. No. Only that they were anti-psychotics, but I don't know the names of them specifically, or placebo.

Q. Thank you.

COMMISSIONER GIBSON: Can I also just check what was the age range of the participants in these trials?

A. The last one I can recall was at St John's, so the people would have been in their 20s and upwards, but prior to that it was at the training centre, so they would have been children down to the age of five.

CHAIR: Thank you.

COMMISSIONER GIBSON: Thanks.

CHAIR: While we're still asking questions, in your brief of evidence on the electric shocks it says primarily through belts but also through helmets.

A. Mmm.

Q. I think we better just explore that a little bit too.

A. Yeah, I never saw them in action, but they were something that I knew was in the literature and had been discussed as the possibility of being there-- was a technician that worked at Māngere who developed all these things specifically, and he was building or making (inaudible) helmets, but they were never used at the training centre.

Q. They weren't used?

A. No.

COMMISSIONER GIBSON: Were they ever trialled? How were they known to work?

A. In terms of?

Q. Helmets and belts?

A. Whether the effect reduced the behaviour?

Q. Or whether they gave the effect of a shock or anything like that?

A. Oh, right. I think by the reaction of the person they put it on.

Q. So, was that staff or the technician themselves or perhaps residents?

A. It would have been the technician - no-, not the staff, the technician would have worked alongside the staff and asked them to place the belt on and then see if there was a reaction when a certain shock was given. I don't know about the helmets, but I did know that happened with the belts.

Q. Thanks.

CHAIR: Thank you.

QUESTIONING BY MR THOMAS CONTINUED: Just one further question picking up on the Commissioner's questions about the trial of the drugs. Was there any involvement of a

medical practitioner?

A. Yeah, there was a paediatrician based at the hospital on staff.

Q. Was that person directly involved?

A. Yes, he was one of the authors of the research.

Q. We might move on to another technique that - I'll- come back to time-out boxes and seclusion, but and-- deal with that shortly, but you mention cold showers and fire hoses being used. Can you give any examples of that?

A. They were used if particularly-- if a person was incontinent, they were typically the go-to to for- staff, nursing staff in the units. So that's where I saw it happening. It was never -used we- didn't have showers at the training centre, -but yeah--.

Q. So, fire hoses being used on residents to clean them, how would you describe it?

A. As a punishment, yeah, for being incontinent, mmm.

Q. Was that a common occurrence.

A. Yes.

Q. On different aged residents?

A. Mostly older residents, yeah. The unit that had the younger children in was run by a charge nurse who was one of the better charge nurses, I never saw any aversive procedures being used in that unit, and it was a very open unit, you could come and go.

Q. So, the practice may vary between units?

A. Absolutely.

Q. What about the spraying of water to the face, can you give us an example of that, how that was used?

A. Just from a spray bottle as --

Q. To discourage a behaviour or?

A. To respond to a behaviour, an unwanted behaviour.

Q. Any specific examples that come to mind?

A. Regurgitation was one.

Q. Removing attention, you mentioned was a practice?

A. Mmm.

Q. How was that carried out?

A. Usually by removing the person from the environment outside or in a day room. It was used at the training centre as well.

Q. So, taking a person out of a situation?

A. Mmm, mmm.
Q. I'll come back now to time-out boxes and seclusion.
A. Mmm-hmm.
Q. I just wanted to know if you could give a bit of a description, I guess, firstly, of the time-out boxes, like, yeah, what were they like?
A. They were built they- were in the training centre, I -don't they- did have them in the units as well, in two that I can think of, but we had two at the training centre, and they were small, square boxes that had no roof on them and were just built into a corner with a lock on the outside and- were made of a plywood or something like that.
Q. Can you give us an idea of how the-- height of these boxes, roughly?
A. They didn't reach the ceiling, I don't know how in- a normal building what the pitch, what the height is, but they were about sort of that far off the ceiling, so -over a-- person of my height could put their hand up and put their hand-over the top, but only just, you couldn't climb out of them.
Q. There was no roof on them, if you like, or top?
A. No, no.
Q. But they were locked from the outside?
A. Yeah.
Q. And how were these used?
A. They were part of a behaviour programme typically for response to aggressive behaviour, sometimes self-injurious behaviour and a person when they engaged in this specific identified behaviour were restrained and taken down to the timeout box and placed in there until they were calm.
CHAIR: Restrained how?
A. By physical restraint. So, one of the nurses the-- nurses that were in the room with the training officer, and the training officer, would take the person down.
Q. By holding them physically?
A. Yeah, moving them.
Q. Not tied or?
A. No, no, no.
Q. Thank you.
QUESTIONING BY MR THOMAS CONTINUED: You mentioned they could remain in there until they'd calmed down, so I take it was there no set time?

A. No.
Q. And were they able to move in the boxes?
A. Minimally.
Q. Could they - they- could stand and sit?
A. They could sit, but yeah, most sometimes- when they calmed,- they sat, but most of the time they would stand and smash against the wall or bang their heads against the walls and scream.
Q. I guess what's the longest period of time that you're aware of, of a resident being in one of these boxes?
A. Over an hour with one young boy for-- biting.
Q. I guess, are you aware of any other accounts of residents being in there longer than that?
A. Not at the training centre, no.
Q. Was there any separate use of seclusion or would you say that was the form of seclusion that was used?
A. No, people could be locked in a day room, locked in another area to separate them out from others. Not, yeah, down in the units that happened frequently.
Q. And would that have been a specific seclusion room or?
A. No, I don't recall there being specific rooms that weren't used for something else as well.
Q. So just locked in another room away?
A. Mmm.
Q. Any, like, indication of how long they might be in a seclusion room?
A. A long time.
Q. Hours?
A. Mmm, I would yeah--.
Q. How would they get out?
A. When the staff unlocked the door. The staff all had master keys, so the doors were they- had -a some-- of them had a window or a double Perspex, but when the staff let them out.
Q. Was it based on whether they'd calmed down or not or was it variable?
A. In some occasions they were used as somewhat of a supervision, so if the staff were low in numbers or it was a tea break and there was a person, two particular people who didn't get on, one would go in there and the staff would be with the other person with the rest of the group.

Q. Was that due to lack of, sort of, staff numbers, what do you put that down to?

A. Well, yeah, they weren't ideally staffed, so in the units there might be 10 or 15 people in a day room and two staff and one's got to go for a break.

Q. Moving on to physical abuse that you witnessed, particularly between residents you describe, can you talk about that?

A. I never saw a staff member hit a client or resident, I had it reported to me from them that they'd been hit by a staff member. But there was a lot of aggression between the people who lived there, and it did it-- seemed to be encouraged or a bit of a sport for some staff to allow that to happen, or to provoke it to happen. Yeah.

Q. What about biting?

A. Yeah, there was lots of different types of aggression, but biting commonly occurred with some people. And I think I mentioned in my statement that there were, it was well-known that if a person was -a the- biting was difficult -to was-- entrenched and sort of difficult to avoid or to prevent, they would have their teeth pulled out and the twins that I talked about were two that that happened to.

In fact, in one of the houses I worked in for Spectrum Care there were five men and four of them had no teeth and they were in their 30s.

Q. So, all of their teeth removed?

A. Mmm.

Q. By a dentist?

A. Yes, there was a dental clinic at Māngere Hospital.

Q. Sorry, going back to the assaults I guess, or aggression between residents, how can-- you give us an idea of how serious these could be?

A. There was blood and there was one incident of a young man who I didn't know about, I found out about it later when I worked at Spectrum, he was living in one of the homes, and he had been kicked in the head by a person in his unit. The two were known not to get on, and not to tolerate each other very well, and he was kicked in the head repeatedly and lost his sight as a result. And I find it difficult to believe that that couldn't have been stopped before it got to that extent.

Q. With that particular incident, were staff aware of it?

A. Yes, I heard from yeah--, I heard that they were watching it.

Q. And could have intervened?

A. Mmm.

Q. But didn't?

A. No.

Q. Moving to sexual abuse at Māngere, yeah, what were you aware of in that regard?

A. I was -- the most-- the areas that I had the most knowledge of were the teasing and ridiculing of two particular residents of St John's who were engaged in a sexual relationship and staff would constantly wind them up about it, particular staff, and tease one of them to -- or insinuate that there were other people that were interested in the person that he was having a relationship with to make him jealous and upset, and he would escalate, his behaviour would escalate quite rapidly and get really upset about it. So that was a frequent occurrence.

Q. Any comment on why they might have done that?

A. Probably because they were both males.

Q. Was there any, I guess, sexual abuse that you witnessed between staff and residents?

A. Not that I witnessed, but I suspected, there was one person who was physically and sexually abused, I believe by one of the staff nurses and he if- you asked him and said something, "Did so and so", he would shut down and refuse to talk about it and ask you not to say anything, -and yeah--.

Q. You talk about staff sometimes taunting residents and mentioned a particular example relating to trucks. Can you tell us about that?

A. The same person who used to wind up these two gentlemen also used there- was one person who was obsessed about the trucks that came in to -the into-- St John's with the work for them to do, and he knew all the names of the different trucks and h e knew the drivers and he got very excited when they turned up. And this person would say, "The truck's coming, I can hear it", so he would go flying down the driveway and there'd be no truck, and he'd come back, and this staff member would laugh and have a grand time at his distress.

Q. Changing topic slightly, you talk about Depo Provera being used --

A. Mmm.

Q. -- as a form the of contraception. How widely used was that?

A. I think it was more used as a means to prevent menstruation and it was most of the females of that age.

Q. Did they consent to that?

A. Not that I'm aware of. Many of them would have found it difficult to give informed consent, but those that could, I doubt were asked. In fact, yeah, I've seen it being

administered without consent, where the person's actively resisting.

Q. We've talked about some forms of psychological abuse already, but you do mention punishment tactics being used by staff. Is there anything else you wanted to say about that?

A. Other than what I've already talked about?

Q. I think, yeah, you may have already covered it. At para 2.23, when you talk about the use of fire hoses or cold showers?

A. Mmm.

Q. You've covered that?

A. Mmm.

Q. Moving on to neglect and the different forms that took, privacy, was there privacy for residents?

A. No. No, there were no units that had their own bedroom space or areas that would there- were sometimes curtains between them, and no -ability I- think in all of- the units all the toilets were open, the showers were open. They didn't have their own personal belongings or personal clothes. There were no doors on the toilets at the training centres either.

Q. What about if residents needed to change their clothes, could they do that?

A. No. No, the clothes came out in a big bag at the beginning of the day, in a big white linen bag and they were pulled out of there. Each unit had a colour t-shirt so when you saw them walking around the grounds you knew which unit it was by their colour t-shirt.

Q. Okay?

A. The one unit they had their own clothes was unit 11 with the children in it, they had clothes that they seemed to wear again and again, so I assume they had their own there.

Q. Would they have those clothes for the day, like you mentioned, they'd have their colour for the unit and that was it for the day?

A. Yes, yeah.

Q. Any other personal effects that residents had or were allowed?

A. Infrequently there'd be one or two people that would carry a particular object, and one person I worked with later in the community, he had that, he had a ring like a, I can't remember the name of the game, quoits, he had a quoits ring and when I met him again in the community, he still had that. So, he had that for 10, 15 years, but that was unusual.

Q. What about other stimulation or entertainment, or activities, was that available to residents?

A. Not within the units. There were no, yeah, no toys available or no equipment outside. The

grassed areas were fenced and there was nothing in the grassed area, you'd often see them walking, pacing out there, there was nothing no-- balls or toys or equipment that older people could use.

Q. You mention one particular instance of seeing in-- relation to toys, can you tell us about that?

A. Yeah, in the afternoon we would take the children back to the units and open up the back door and put them in the big day room and I had the job of, one day, of dropping a c ouple of people off and they had - I'd seen them before, they had toys pinned up above the sort of top, yeah, high up above the walls and, for whatever reason, that day I decided to get some down and give them to the people that I'd brought back, and then left. And then I got called in to my boss's office the next day and told there'd been a report that I'd done that, and then I -got had-- to go and see the chief, whatever he was, doctor somebody, and was told, yeah, was disciplined for it and told I wasn't to go back to that unit, that the charge nurse had banned me.

Q. Would you know why the toys would have been pinned to the walls like that?

A. They were inaccessible there, it kind of looked nice, but they were decoration and inaccessible to anyone.

Q. What sort of was- it- children in this area?

A. They were mid-teens and older, or people who were nonverbal and quite severely intellectually disabled.

Q. Was there a reason for them to be pinned up on the wall?

A. So, they wouldn't be ruined.

Q. So, they could see them but not use them?

A. Mmm, mmm.

Q. How did you feel about getting a complaint about that?

A. A little probably-- rebellious, bitter, but, yeah, I would have done it again if I'd had the chance.

Q. Talking about cultural neglect now, is there anything in the way of recognition of culture at Māngere?

A. No. There was, yeah, a wide range of people from different ethnicities that lived there, and there was never there- was- never any attempt to make any connections for them with their ethnic backgrounds or provide any cultural activities.

Q. Were there celebrations for special events, birthdays, that sort of thing?

A. Not that no--, not that I can recall.

MR THOMAS: Madam Chair, sorry, I'm just conscious that I'm running over time slightly, I'd expect...

CHAIR: I think we should carry on.

QUESTIONING BY MR THOMAS CONTINUED: Thank you. I'm nearly on to the final couple of pages. I wouldn't expect to be too much longer.

What about in terms of medical care, was that available at Māngere?

A. That was all in-house, so the nurses were all trained medically. The doctors, there were the-- main boss was a doctor, he was a paediatrician, I think, and there was one other paediatrician that I'm aware of, but they weren't there-- wasn't the level of care they- never got outside care, so -no one- was ever taken to a hospital that I'm aware of.

And there were lots of situations where people were clearly medically neglected. There was one man I worked with in the community later, who I didn't know at the hospital, he was actually one of the people who I'd seen on my first visit and he was very physically disabled, and he -- and lots of contractures and he'd had his two legs amputated because his contractures had developed where the skin was not able to get any air, they'd developed quite significant wounds and sores and he wasn't -- and he was one of the people that went to Māngere as a young child, so he wouldn't have been that bad when he first got there, but because he hadn't been given proper physiotherapy and other treatment, his legs were amputated.

Q. You mention another example of a resident who was ingesting items, can you tell us about that?

A. Yeah, it was well-known- that she would ingest non-nutritive items such as bandages and plasters, other bits of cloth, and it was assumed that she did it because -she it-- was a behaviour that she enjoyed, and she died, and it was later found out that she'd died from ulcers, she had a perforated ulcer. So, she was possibly ingesting them to try and reduce the symptoms of the ulcer.

Q. I take it that was an undiagnosed ulcer?

A. Mmm-hmm.

Q. Stomach ulcer?

A. Mmm.

Q. You mention that some units were perhaps better than others --

A. Mmm.

Q. -- within Māngere. Was that down to who was running the unit?

A. Yeah, and then which staff were attracted to work there because of the person running the unit. So specific types of people liked to work in specific types of units and that particular one had some really amazing nurses and had a close relationship with the training centre. So, they would come up frequently and we would go down and, as I said, it was quite an open-door policy. And he that-- charge nurse came away with us when we took the kids camping. He was the only one who did.

Q. What were the residents like within that unit?

A. They were young, the younger children, and all the day stay children not -- day stay, sorry, respite children that came in for a break and then went home to their parents again.

Q. Was deaf culture catered for at Māngere?

A. Not until later. There were some residents who signed amongst themselves and some of it was iconic sort of signs that they had developed, but later when they lived in the community there was a connection with Kelston and some deaf staff were employed into the homes, but not at Māngere.

Q. That must have presented particular challenges for those residents, I would imagine?

A. Mmm. Yeah, they were treated, unfortunately, the same as a person who was non-vocally verbal, and yet they were quite capable.

Q. Moving to complaints, was there a complaints process at Māngere?

A. Against for-- the staff?

Q. I guess, for both, for residents --

A. No.

Q. -- firstly?

A. No. No, there was no process. There was nothing to stop you making a complaint as a staff against a staff, and parents complaining, I think that occurred occasionally, but there was no complaints process or complaints procedure to follow up and resolution for anything that was brought forward.

Q. Would people, would staff feel that they could complain, in your view?

A. No, no.

Q. Why is that?

A. I think there were too many staff that were, the weight or -- the majority was the people who were in the role that shouldn't have been in the role and so the culture was more, ignore it, move on, than standing up for people's rights.

Q. Would you face repercussions if you did complain?

A. I'm not sure, apart from ostracising, being ostracised, I don't know if there'd be complaints that were, yeah, sort of more serious like being put on nightshifts on a frequent basis or being put into a unit you didn't like working in.

Q. But you might be ostracised amongst other staff members if you complained --

A. Definitely.

Q. -- about staff?

A. Yeah.

Q. What about a complaints process for residents, could they make a complaint?

A. No, well, there was no process; certainly, no encouragement to do so.

Q. Non-verbal residents?

A. No. Most people who didn't have families connected also didn't have any welfare guardians or other advocates, except for the staff that might like them.

Q. Was there any ability for a resident to complain externally, say to the Police or another agency?

A. I think the only I- can't think of any opportunity for them to have access to anything to be able to do that or- leave the premises to be able to do that. All the units mostly were locked, and access wasn't, or egress wasn't available without staff. It was a long way down the driveway to the road.

Q. Moving, perhaps, to the final part of your statement now, what would you like to see done better in the future?

A. That's a big question.

Q. In your statement you mention things such as financial barriers, funding limitations. Do you think anything should change there?

A. Yeah, and specifically sort of for the personnel that are supporting people who need support, the training, appropriate training and mentoring and supervision. But yeah, money would make a difference. I don't --

Q. Better pay as well?

A. Yeah, I mean, the people who live in residential care now, many of them live in, not all of them, but many of them that have to live in residential care are in homes of people they don't know, that they haven't chosen to live with, and living in numbers because it's more economical to do that. So, yeah, if there was more money then that wouldn't necessarily have to happen.

Q. You mention evidence-based care. Can you expand on that?

A. Yeah, I mean everybody can learn skills if the right approaches are used, and if the right environment and context is provided. So, the evidence is really clear that if we get in early with children who have been identified as at risk of developing a disability or have a disability, that we've got a good chance of improving their skills, so they are more independent and more able to function without needing as much care and support. But we don't do that, we wait until it's a problem and then we offer cursory or, not cursory, but limited support.

Q. What about special schools, any comment on how they operate, or could - how- you'd like to see them operate?

A. Using that same approach, the evidence-based approach to teach people, not just have them in a setting because they can't manage them in a mainstream setting or manage their behaviour or adapt the curriculum. The special schools that we have that I have been in and around in the last few years have hallmarks of Māngere and other places I've worked in where there's limited individualised treatments and approaches.

Q. You mention you'd like to see purpose-built homes where possible?

A. Mmm.

Q. Do you want to expand on that?

A. Yeah, the difficulty yeah-, people who I worked with that had quite significant physical disabilities and needs, it was often not set up for them and so they -were - people- were trying to care for them in a situation where, yeah, they couldn't even bath or shower them properly, they didn't have all the equipment they required. There are some improvements in there, but there is still a long way to go.

Q. Just on that, a final question. Looking back on it during your time at Māngere in the 1980s, is it any better now for people with a disability, as you see it?

A. If you were just to compare that environment to what we've got now, there is improvement, it's not ideal, it's not we're-- not there. But there's certainly more there's-- more focus on providing appropriate care, but there's still huge deficits in the care that is provided.

Q. Thank you. I'll just pass you over to the Commissioners for any further questions.

COMMISSIONER GIBSON: Thank you, Sheree, I'll start off with some questions. What training practices from back in the day, back in the 80s seem to work, do you think, or seemed to work at the time?

A. Focusing on specific skills, so the curriculum that we had where we were able to assess a

child or an older person, up to a certain age, and work out what specific communication needs they needed, what letter skills they needed, what social skills, what functional motor skills. So, targeting those skills and working in those systematically was effective and it was, yeah, only that-- was the one good thing about the training centres was that there was a focus on teaching skills.

Q. And today in schools, schools and other environments, what are the evidence-based practices that we know of that are working and what are the ones which we should leave behind?

A. I think there is still I- think there's a massive gap in understanding why unwanted behaviour occurs still and there's not a careful analysis done of why somebody might engage in something that is either aggression, you know, topographically unwanted, and working out what an alternative behaviour is. That is still not occurring. And there is not appropriate curriculum adaptation for the people who are in the schools. So there's an approach, -one size- -fits -all kind of approach. I don't see individualised plans, yeah.

Q. Do you think we have, if I were to broadly call this a behaviour support workforce in schools, do we have the right training, the right capacity and capability, enough people doing this kind of work, is it available to schools and families?

A. I don't think there's enough, it is available, but there's long, long wait times, for families in particular. And there are, in terms of schools, it's a very consultative model, so there's not enough going in, and enough training for teachers who are at the coal face basically.

So, the teachers that work in specialist schools are not necessarily engaged in further training or have often come out of mainstream and straight into that setting and it's a completely different need in those settings.

Q. Thanks.

Commissioner Steenson, do you have any questions?

COMMISSIONER STEENSON: Yeah, I just have one question. Kia ora.

A. Kia ora.

Q. You talked about the at-- Māngere there were 660 residents living in 11 units and Baker House?

A. Mmm.

Q. Can you just give us a sense of the demographics or the majority demographics?

A. So, they ranged in age from four to five right through to elderly and they were in - some cases in units based on their age but in some cases the older people were more

based -in were-- in units based on their need, their functional need. So, people who had physical disabilities were in specific units that were more set up for them than others.

Q. So, it was quite a spread age wise?

A. Yes.

Q. There was no specific age group?

A. No, no.

Q. And what about ethnicities, the majority ethnicities?

A. The majority would have been Pākehā, but there were a substantial number of Pacific Islanders and Māori and Asian, Indian, some other European ethnicities, mmm.

Q. Okay, thank you.

COMMISSIONER GIBSON: Commissioner Shaw.

CHAIR: Sheree, this has been extremely interesting evidence and I think shocking in many regards. I use that word advisedly. I have two particular questions. The first is about your training, just to go back to where I started.

A. Mmm-hmm.

Q. Who was responsible for your training, who was employing you? Was it Education or was it Health or who was it? Which Department?

A. It was Health. So, it was the Area Health Board which and-- then became the District Board or the other way around, the same as what we're doing now, from one to the other.

Q. Whatever they were, let's just call it Health.

A. It was Health, yes.

Q. So, Health made the decision to have its own training programmes?

A. Mmm-hmm.

Q. And I take it were- there- other educational facilities at Māngere?

A. No.

Q. So, the Education Department, for example, didn't have any role --

A. No.

Q. -- in education of any sort at that residence?

A. No, there was a special school down the road, and I can recall in the time I was there that maybe two of the people who lived at Māngere, three, went from Māngere and to the special school, but the rest came to the training centre, or stayed in the units.

Q. Right. So apart from your training there was no education provided at Māngere?

A. No.

Q. Thank you. And my second question arises from your evidence about unit 11, which you describe as being a unit that was well-run, a good charge nurse who understood and took care.

A. Mmm.

Q. And there was a very nice environment and very nice culture th ere in that place.

A. Better than the rest.

Q. All right, perhaps I've overstated it, better than the rest, but a contrast between that and other places where you've described behaviours and practices that are obviously less than acceptable?

A. Mmm.

Q. As somebody who was in there but not part of all those units, did you have a sense that there was anybody who was part of that management that kept an overall view of the standards and the cultures and the behaviours in each of the units?

A. No. It was very much a the-- charge nurse runs it the way they want to run it, and the charge nurses of those units, their culture, their personality was very evident in the way that the units were being run. And there wasn't much change in terms of the people runn ing them either, they stayed in those positions for a long time.

Q. Right.

A. So, there were supervising sisters above them, typically, but they had very hands-off approach, there was no unifying sort of level of code of conduct or standards.

Q. Yes, that's what I'm really going to, you're right, and consistent standards of --

A. Yeah.

Q. -- care, consistent values, nothing like that at all?

A. No, no, no.

Q. So, each of these charge nurses was pretty well, a law unto themselves?

A. Yes, yeah. And it was -- that was, yeah, very evident if you looked at a place like Baker House which was also run very well, they were very medically fragile children there, and it had a nice feel and sense about it, and unit 11, and then you walked into unit 8 or uni t 9, it was like -- it was disgusting, there were people that weren't changed, they had no - they were just walking around with filthy clothes on. And they were clearly also not fed sufficiently, when the food truck came there was a massive sort of, like, in those places particularly, onslaught to the door, yeah. In some units people were underweight - and in other units they weren't.

Q. So, the next question this-- goes to the systems at play there.

A. Mmm.

Q. There was a Medical Superintendent or was there an overall person in charge?

A. There was.

Q. And do you know what role that person had in all of this?

A. I never saw him in the units, he was in the - the- photo that you showed of the doors, he was in there, in the office at the end and I never saw him leave there.

Q. And we will, of course, look at the lines of responsibility and who was responsible for overall care there.

A. Mmm.

Q. And there is one question that's just occurred to me. You talked about medical neglect, and there were nurses and doctors on site, was there a hospital wing or a hospital place where people with illnesses would be placed to care for them?

A. No, no, it was all care in the unit. The only other separate unit was the dental unit.

Q. That would be just to go and have your teeth attended to or removed or whatever?

A. Yeah, they did general anaesthetics there too.

Q. There was no residential place where an ill person could go, be treated in a hospital like environment before being returned to the unit?

A. No, and I'm unaware of anyone ever going to a general hospital that lived there. They did when they were in the community, but yeah.

Q. Thank you. I think we've asked you quite sufficient questions for today, but I'm just going to ask you, would you be prepared, should we need further information, to be available for questions, offline not in public, would that be all right?

A. Sure. Yes, yeah.

Q. Very grateful for that. So just a massive thanks from the Commission to you for the contribution you've made, you've put a lot of work into your brief, we can see that, and the evidence you've given today, as I have said, is in some regards quite revelatory and very, very important to the work of the Commission, and for that we thank you very much indeed. So, you're now free to go. Thank you.

COMMISSIONER GIBSON: Thank you, Sheree.

Now, to close off for the day, can I hand over to the kaikarakia.

Karakia mutunga and waiata He Hōnore by Ngāti Whātua Ōrākei

Hearing adjourned at 5.15 pm to Wednesday, 13 July 2022 at 9.30 am