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HILARY STACE - AFFIRMED
EXAMINED BY MS JANES

CHAIR: May I ask you as follows, in terms of the
Inquiries Act 2013 (witness affirmed).

MS JANES:

Q. Is your full name Hilary Janet Serena Stace?

11.38 A. Yes.

Q. And you have prepared a statement for the Commission?

A. Yes.

Q. Have you found it at tab 12 in the folder in front of you
and you've signed and dated it?

A. Yes, I have. Can I start?

Q. Yes, that would be good, thank you. Dr Stace, you have a
PowerPoint that you would wish to use as you read your
statement.

11.39 May it please the Commission, we will produce that
as an exhibit as it has some additional material not in
the written brief.

A. Yes but most of it is just summaries of my points, it
makes it easier for me to go through my presentation.

Q. That will be Exhibit 7.

PowerPoint produced as Exhibit 7

A. Is it going to work? Yes.

11.39 Q. Dr Stace, just before you start reading, you've asked to
read your brief of evidence, so just before you start
that, can you confirm please that any third parties that
you refer to are either sourced from public or you have
the consent of the people to speak about them?

A. Yes, yes.

Q. Thank you. If you'd like to start reading at
paragraph 1, thank you.

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1 A. Kia ora everybody. It's been a long road to get to this
2 point. For many of us, it's been a long, long journey of
3 advocacy to get here, so it's a great privilege.

4 I wanted to start with my own expertise in this
5 area. I am a mother of a disabled adult son and he's
6 from the first generation not to be institutionalised and
7 the first to have the right to an inclusive education. I
8 was trained as a historian and librarian and I did
9 Honours Research on Eugenics in New Zealand. My 2011 PhD
10 was in public policy at Victoria University and the
11 subject was The Policy Challenge of Autism.

12 In 2013-2014, I had two short contracts with the
13 Human Rights Commission to work on historic abuse in
14 State care and as a result, organised a round table of
15 interested parties on this topic.

16 I am a writer, a teacher, an activist in disability
17 rights, history, ethics, research and advocacy. And my
18 current status is actually a Professor of the Health
19 Research Centre at Victoria University, it is an honorary
20 role. It doesn't actually mean much.

21 Q. Can I ask you to perhaps slow down a little bit, thank
22 you.

23 A. Yes.

24 Q. According to Te Ao Maori, we walk backwards into the
25 present and future bringing those who came before us,
26 their battles, knowledge and suffering. We honour them
27 and learn from their stories. In previous work at the
28 Human Rights Commission we used the whakatauki: Titiro
29 whakamuri, haere whakamua (ask the old path for
30 directions to the new path).

31 We need to know our history in order to address it
32 and help us understand why certain groups were locked
33 away from communities and families for who they were
34 rather than anything they had done. As disability

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1 advocate Robert Martin asks, how can humans treat other
2 humans like that?

3 This paper mainly covers 2.1 of the Scope of
4 Investigation but also addresses 2.2, 2.4 and 3.1. It
5 covers the background to the development of the
6 psychopaedic institutions, the political, scientific and
7 social environment that encourages extreme discriminatory
8 practices against certain groups of people and the legacy
9 of that.

11.43 10 Q. Dr Stace, we might skip paragraph 3 because that's
11 repetition, and if you can go to paragraph 4.

12 A. Yes. The Royal Commission's focus is 1950-1999 but this
13 paper reviews the social and the legal, medical and
14 attitudinal context in New Zealand since the mid 19th
15 Century that enabled such abuse to happen. And it also
16 looks at ongoing disability abuse and restorative
17 processes required.

18 There were two official inquiries in the 1950s that
19 sought to control the 'defective', the 'deviant' and the
11.44 20 'delinquent' which were the interchangeable fears of
21 conformist New Zealand in the 1950s when this Inquiry
22 time period starts.

23 When I was a baby, my father was appointed to the
24 Government's Special Committee on Moral Delinquency in
25 Children and Adolescents which produced what was known as
26 the Mazengarb report in 1954.

27 In an era of 'moral panic', the intention was to
28 control this potentially deviant phenomena of teenagers
29 in the new state housing suburbs such as Naenae near
11.44 30 Wellington.

31 The Committee rushed its hearings so that the report
32 could be sent to each household for the National
33 Government's re-election campaign. My father was head of
34 the Jaycees, the Junior Chamber of Commerce. Judge

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1 Mazengarb told Prime Minister Sid Holland that the
2 Committee members didn't need to be paid, so my father
3 attended the full-time Committee while parenting his
4 growing family and keeping his small business going.
5 Meanwhile, my sister shared the evidence presented to the
6 Committee - such as Mickey Spillane novels - with her
7 school friends.

8 The Committee decided that the best way to prevent
9 such deviants was to keep young people ignorant, so we
11.45 10 got new censorship laws. And one recommendation that
11 took decades to overturn was that under 16 year olds must
12 not have access to information about contraception.

13 This fear of young people and their potential
14 delinquency also led to the rise of state boys' and
15 girls' homes. A few years after the Mazengarb report,
16 the Epuni Boys' Home was opened in Naenae in the heart of
17 the new suburbia where the Committee had located such
18 threat. In this Royal Commission we are hearing a lot
19 about the long-term effects of abuse from such homes.

11.46 20 But more significantly for disabled people and
21 families, was that the previous year, 1953, another
22 government report responded to the fear of deviance by
23 recommending that disabled children should be locked away
24 from their families and communities in larger numbers
25 than ever before.

26 The 1953 Aitken Report, or the Consultative
27 Committee on Intellectually Handicapped Children,
28 recommended extending the existing psychopaedic
29 institutions such as Templeton, Levin, Kimberley,
11.46 30 Braemar, Ngawhetu and Mangere into large 'mental
31 deficiency colonies" with parents encouraged or coerced
32 into sending their disabled children to them by the age
33 of 5. These recommendations were despite pleas from the
34 newly formed Intellectually Handicapped Children's

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1 Parents Association, the IHC, founded 70 years ago this
2 month, I honour those parents, and the World Health
3 Organisation advice for community facilities and support
4 for disabled children and adults, not locking up.

5 But the Aitken Report is a significant reason why we
6 have a Royal Commission today.

7 As a result of this report, the institutions were
8 extended and numbers of residents rapidly increased. By
9 1972, and the establishment of the Royal Commission on
10 Psychiatric and Psychopaedic Hospitals, which would
11 eventually recommend their closure, each institution was
12 home to hundreds of disabled children, young people and
13 the few adults who had managed to survive.

14 A 1964 documentary estimated that one in a thousand
15 children had an impairment which required their
16 institutionalisation.

17 Smaller units were attached to some local hospitals,
18 while other children ended up in adult psychiatric
19 hospitals. To deal with these growing numbers, the new
20 profession of specialist psychopaedic nurse, you heard
21 about before, was developed in New Zealand with in-house
22 training. The first cohort graduated in 1964.

23 The normalisation of institutionalisation of
24 disabled children was hard for individuals to fight. I
25 heard of a mother who had a baby with Down Syndrome in
26 the 1960s. The family doctor and her husband suggested
27 the baby be put into an institution. The mother resisted
28 until one day the father came home with the GP and an
29 attendant from Kimberley, they forcibly took the toddler
30 off his mother, told her not to visit for at least 2
31 years and to forget about him. Terrified and confused by
32 such instruction, the mother didn't hear about him again
33 until after his death a few years later. This
34 powerlessness by mothers was hard, is hard for us maybe

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1 to understand now.

2 As noted already, this topic is also personal to me
3 as I have an adult son with autism and learning
4 disability. Christchurch film maker Gerard
5 Smyth has made two powerful documentaries about the
6 closure of Templeton institution. The residents he
7 filmed were much like older versions of my son's Special
8 Olympics friends. So, most of the interviewees in his
9 documentaries were estranged from families and puzzled as
10 to why they were there.

11 My son was born in the 1960s (sic) 1980s when
12 institution closures were already underway. So,
13 as I mentioned, we are the lucky first generation of
14 parents for whom an institution was not suggested as a
15 suitable place for him. I wasn't told he would
16 be better off in one. He wasn't forcibly
17 separated from his family or community. His impairment
18 is not blamed on me or a cause of shame for the family.

19 Both assumptions were common only a few decades
11.50 20 ago.

21 The 1953 Aitken Report, it didn't come out of
22 anywhere. New Zealand has a - in New Zealand, we have a
23 toxic, a long and toxic mix of colonisation, racism and
24 eugenics in which many poor Maori or disabled people had
25 no chance of equal citizenship. The antecedents of
26 institutional abuse in State care developed over many
27 decades and I will attempt to explain why disability was,
28 and still is, viewed negatively.

29 19th Century New Zealand was settled by immigrants
11.51 30 mainly from Britain and Europe who endured a lengthy sea
31 voyage for a chance of a better life in a new country.
32 Two groups which threatened that vision were disabled
33 people and people from Asia.

34 Although infectious illness and accidents were
common, disability was unwelcome as it challenged the

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1 ideal of a new society and was a burden on others at a
2 time when hard physical work and self-reliance were
3 highly valued. Support was left to the benevolence of
4 family or charitable aid.

5 The immigration acts that restricted the entry of
6 Chinese in the late 19th Century, also sought to deter
7 disabled people. One was the 1882 Imbecile Passengers
8 Act attempted to ban 'cripples, idiots, lunatics, infirm,
9 blind, deaf and dumb ' and required a bond from the
11.52 10 ship's captain for each of those 'undesirables' and the
11 1899 Immigration Restriction Act banned the 'idiot', the
12 insane and contagious.

13 In 2019, we still have immigration restrictions
14 against disabled people.

15 Mental illness, as now, was generally feared and
16 misunderstood. The 1846 Lunatics Ordinance provided
17 incarceration of the mentally ill, initially in jails.
18 The first public 'lunatic' asylum was opened in Karori in
19 1854, followed by Porirua in 1887. The Porirua asylum
11.53 20 mixed several categories of these undesirables, those
21 with mental health issues, intellectual impairment,
22 alcoholics as well as elderly and homeless people.
23 Physically disabled people were often also housed in the
24 so-called 'chronics wards' in ordinary hospitals. For
25 decades, all these inmates also provided large captive
26 communities for doctors and specialists to practice
27 theories and treatments.

28 As New Zealand society developed, children came to
29 be regarded as more than little adults. The 1877
11.54 30 Education Act provided free, secular, primary school
31 education. The Act's aim was an educated workforce while
32 enabling State surveillance of children. Rules and
33 inspections were rigid.

34 Segregated residential schools developed at this

1 time too for those with vision and hearing impairments.
2 But deaf children were forced to be oral and punished for
3 signing for most of the next century.

4 The rise of the pseudo-science of eugenics and
5 Social Darwinism became very influential. In 1859
6 Charles Darwin published his best seller on the origin of
7 species by natural selection or the preservation of
8 favoured races in the struggle for life. The ideas of
9 evolution, genetics, heredity and the potential of
11.55 10 selective breeding in humans, not really what Darwin was
11 talking about, to breed out these undesirable
12 characteristics. These were taken up by his cousin,
13 Francis Galton, who named the new science eugenics. The
14 application of 'Social Darwinism' found fertile soil in
15 New Zealand as well as other countries. Here, these
16 ideas were embraced by liberals and conservatives
17 concerned about the white middle class birth rate which
18 had started to decline in the late decades of the century
19 and consequent fears of losing their racial and moral
11.55 20 supremacy. Improving racial 'fitness' was vital.

21 By the turn of the 20th Century, many of
22 New Zealand's leading politicians, doctors and academics
23 believed the scientific validity of eugenics. It was
24 cutting edge science. We were also, as New Zealand,
25 proudly part of the British Empire and its mother country
26 or home, as a lot of people called it.

27 Their eugenic targets of this population, the white
28 population, were those considered immoral and dangerous
29 who threatened racial fitness. In New Zealand, disabled
11.56 30 or mentally unwell people and Chinese people were the
31 main targets, hence the poll tax and immigration
32 restrictions which I mentioned earlier.

33 In 2002, Prime Minister Helen Clark formally
34 apologised to Chinese New Zealanders; disabled people are

1 still waiting.

2 Two influential Social Darwinists were Duncan
3 MacGregor and Robert Stout. MacGregor from Scotland was
4 Professor of Mental and Moral Science at Otago University
5 and advocated in the 1870s for extension of the
6 definition of insanity to include 'hopeless drunkards,
7 hopeless criminals and hopeless paupers', so that these
8 dangerous classes might be 'made to work for their
9 support, and deprived of liberty until they die, in order
11.57 10 to prevent their injuring society either by their crimes
11 or by having children to inherit their curse'.

12 In the 1880s Premier Robert Stout, a former student
13 of MacGregor who believed moral failings caused poverty,
14 warned of an emerging class of permanent paupers, poor
15 people, which would pollute the new society. His wife
16 Anna was a prominent suffragist. Many feminist writings
17 of the era reflected strong eugenic beliefs particularly
18 as a means to rid society of undesirables such as
19 alcoholics.

11.58 20 In 1903, WA Chapple, who was a respected politician
21 and doctor, published his influential booklet, "The
22 Fertility of the Unfit". The problem he saw was a
23 decline in the fertility of the "fit" and the increasing
24 birth rate of the "unfit". His solution lay in
25 encouraging the "fit" to have more children and by
26 sterilising the "unfit", and those included those with
27 mental, moral and physical defects.

28 I remember when I was a young librarian at the
29 Turnbull Library coming across the book, and it was in a
11.59 30 big collection of books and pamphlets, and I was shocked
31 because I didn't know that opinion basically was so
32 popular in New Zealand. It is a shocking book and yet he
33 is a very, very influential book publisher.

34 The Eugenics Education Society was founded in

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1 Dunedin in 1910 with a leadership of politicians, public
2 servants, scientists, doctors, ministers of religion and
3 academics, one of whom was Truby King, the Medical
4 Superintendent of Seacliff Asylum. They linked
5 intellectual impairment and some physical impairments
6 like epilepsy with inferiority and moral degeneracy.

7 A note here about positive and negative eugenics.
8 Negative eugenics sought to limit fertility while
9 positive eugenists supported interventionist policies to
12.00 10 increase population 'fitness'. In this context, Truby
11 King founded Plunket in 1907. He was a positive eugenist
12 who believed that teaching mothers the strict rules of
13 'scientific' mothering would increase the fitness of the
14 race. Committees of middle class women then took the
15 ideology to the breeding populace.

16 But surveillance of those deemed dangerous and
17 deviant required legislation.

18 So, one of the most significant of these new laws
19 was the 1911 Mental Defectives Act which classified
12.00 20 groups of 'other' into six categories. "Persons of
21 unsound mind", "mentally infirmed", "idiots",
22 "imbeciles", "feeble-mind" and "epileptics", and each
23 category had a description and what should happen to each
24 one of those groups.

25 And then the 1914 Education Act required parents,
26 teachers and Police to report mentally defective children
27 to the Department of Education and the School Medical
28 Service was founded to identify defective children so
29 they could be subject to surveillance. Health camps
12.01 30 developed to temporarily remove children from their
31 families and instill ideals of health and fitness. The
32 new science IQ testing provided a valuable classification
33 tool.

34 By 1922 Committee on venereal disease was led by

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1 William Triggs, a Member of the Legislative Council. His
2 concluding remarks expressed concerns with the role of
3 feeble-minded women infecting men, causing debauchery and
4 corruption. So, here we had another era of moral panic
5 and it was high. So, Mr Triggs was appointed to Chair a
6 Committee of Inquiry into Mental Defectives and Sexual
7 Offenders.

8 The 1925 report reinforced the links between intellectual
9 impairment, moral degeneracy and sexual offending in the
12.02 10 public mind. I have a little quote from that report, the
11 recommendations, "The unchecked multiplication of the
12 feeble-minded and epileptic is leading to a continually
13 growing addition to the sum of human misery and ever
14 increasing burden on the State and the serious
15 deterioration of the race". That was a government
16 report.

17 Theodore Gray was a Scottish clinician influential
18 in New Zealand psychiatric hospital administration. He
19 advocated villas instead of old multi-storey hospitals.
12.03 20 In 1927 he succeeded Truby King as Head of the Department
21 of Mental Hospitals. To protect this white racial
22 fitness he wanted segregated farm colonies for those with
23 intellectual disability or mental illness, registration,
24 screening and sterilisation. These were all proposed in
25 the 1928 Mental Defectives Amendment Bill.

26 After much political debate, sterilisation was
27 rejected under the leadership of opposition Labour MP
28 Peter Fraser who would become Prime Minister a decade
29 later. He was a rare voice against eugenics, possibly
12.03 30 because of his own family experience of mental illness.
31 As a compromise, a Eugenics Board was set up to keep
32 lists of mental defectives. Peter Fraser's wife, Janet,
33 one of the first women JPs, was appointed to this board
34 and I like to think she quietly sabotaged it as it didn't

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1 last long.

2 French-born nun Suzanne Aubert who had personal
3 experience of disability was another component of
4 eugenics. She founded her first Home of Compassion for
5 needy or disabled adults or children in Wellington.

6 So, even though eugenic sterilisation was never
7 legal in New Zealand, we know there is a lot of evidence
8 and anecdote that they were widespread and they were
9 diagnosed and operations such as appendectomies and
12.04 10 witnesses, a lot of anecdotal information about that
11 happening. Something that we need to do more research
12 on.

13 Under the 1928 Mental Defectives Amendment Act
14 children could be taken off families. A mother provided
15 a rare voice of protest against Dr Gray's proposed
16 travelling clinics which would examine intellectually
17 impaired children. There is this rhyme/poem that I found
18 that was apparently also a nursery rhyme. Anyhow, I'll
19 read it:

12.05 20 "Oh Mother, save me from Dr Gray
21 'Cause teacher says he's coming today
22 And if I'm stupid he'll take me away.
23 Oh, Mummie, save me from Dr Gray!"
24 "I cannot save you, my little child."
25 His Mummie said and her eyes were wild.
26 "You belong to the State, you're no more my child!
27 But oh, my darling don't stupid be
28 Or he'll say we've tainted heredity.
29 And must be eradicated - you and me!"

12.06 30 This overview has shown how and why over several
31 decades, intellectual impairment and disability came to
32 be linked with 'immorality'. Reproduction of these
33 so-called 'degenerates' threatened the dominant white,
34 fit society but there was still the legal requirement for

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1 education so in 1908, Otekaiki (Campbell Park School)
2 near Oamaru was opened as a residential school for
3 'feeble-minded' boys and in 1916 a residential school for
4 'feeble minded girls', Salisbury, was opened near Nelson.
5 These special schools were run by the Education
6 Department.

7 The overall effect of these influential beliefs was
8 exclusion of the unfit from -

9 **CHAIR:** Dr Stace, can I intervene simply to ask you to
12.07 10 speak just a little more slowly, the signers are
11 finding your pace quite difficult.

12 A. Sorry. The overall effect of these influential beliefs
13 was exclusion of these groups from mainstream society.
14 Girls and boys' homes, farm and residential schools and
15 other institutions were developed to keep the sexes apart
16 and importantly, prevent reproduction. Some were built
17 on the sites of orphanages or industrial schools as more
18 permanent placements for those who threatened racial
19 fitness.

12.08 20 The 1928 Mental Defectives Amendment Act led to the
21 establishment of our first psychopaedic institution,
22 Templeman Farm mental deficiency colony, in 1929 under
23 the authority of Dr Gray and his Mental Hospitals
24 Department. It was near Christchurch but not too close.
25 The first residents were boys but soon girls were sent
26 there too, although sections were strictly segregated
27 inside the institution. Christchurch filmmaker, Gerard
28 Smyth, recorded stories of the residents before it closed
29 in 1996 and caught up with some of the residents again in
12.09 30 2004. Some had been in Templeton for decades but didn't
31 know why. Some had arrived by bus as small children. Dr
32 Gray personally signed some of the admission forms.

33 Featured in the 1996 documentary, was an older man
34 who had been a Templeton resident from the 1930s. I

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1 recently talked to his nephew about the ongoing impact on
2 their family history. 80 years later this younger man
3 wonders why it all happened. In the documentary, the
4 Templeton resident said he was sent away from where he
5 lived with his mother in the 1930s because he stole two
6 pies. He was only a small child. He was initially sent
7 to Otekaike and then Templeton. He describes regular
8 sexual abuse by the "big boys" and lack of any
9 accountability by authorities. He and another boy ran
12.10 10 away and for punishment were beaten then forced to spend
11 several hours a day in a small dog kennel.

12 As a child, the nephew remembers occasional visits
13 home from Templeton by the older man but the boy was
14 warned to keep away because the older man was rumoured to
15 be, without any evidence, a pedophile. The younger man
16 remembered his uncle would flinch if someone came too
17 close as if to avoid punishment and this reflects the
18 reported Kimberley cringe of patients, residents of
19 Kimberley, that Brigit mentioned.

12.11 20 In relating this story, the man expressed anger at
21 the older man's mother, his grandmother, for not only
22 sending her son away as a child but also refusing to
23 accept him home when the institutions started emptying.
24 But thinking of that poem I read earlier, the poverty of
25 the 1930s, the mother would have had little power to
26 fight the authorities when they came for the young
27 shoplifter. As well as, mother blaming for conditions
28 like autism remained strong into the 1970s and even
29 beyond. Institutionalisation and the consequent shame
12.11 30 and fear that the family experienced has affected this
31 whanau for generations.

32 Over time, more psychopaedic hospitals were
33 established, including Braemar, Kimberley (Levin) and
34 Mangere (Auckland). Residential units were established

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1 in hospitals such as Dannevirke, or in psychiatric
2 hospitals, such as Porirua, which setup an autism unit in
3 the 1970s when that diagnosis started increasing. Many
4 disabled children spent time in mainstream psychiatric
5 hospitals and some examples can be found in the DBI
6 report that was mentioned earlier.

7 And Pukeora, which was an Institute for children and
8 young adults with physical impairment, opened in
9 Dannevirke in the 1950s.

12.12 10 So, support for eugenic policies was widespread
11 globally and it was in this context in 1939 that a German
12 father asked the State authorities in Germany to kill his
13 disabled child. That was the start of the euthanasia
14 policies of the Nazis and it is estimated that over
15 200,000 disabled people were killed in what was known as
16 the 'silent Holocaust'.

17 But support for eugenic policies dimmed in
18 New Zealand and elsewhere but did not die with the Nazis.

19 As mentioned earlier, children with impairments,
12.13 20 including intellectual learning disability, founded the
21 forerunner to the IHC. They wanted schools and community
22 facilities for their children so they could keep them at
23 home and out of institutions, but they faced much
24 discrimination. Oriental Bay residents petitioned
25 against the planned school that the IHC had organised
26 there. The residents of Oriental Bay lobbied the new
27 National Government for support, they petitioned against
28 the planned school and the residents lobbied the new
29 National Government and the - I have lost my place there.
12.14 30 But the discrimination, the school never went ahead. The
31 whole idea went away because the residents of Oriental
32 Bay didn't want the idea of having a school for children
33 with intellectual disability.

34 These parents kept lobbying and what happened is

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1 that they wanted these community facilities but what
2 happened instead, is they got the Aitken Committee which
3 was setup in 1954 that I mentioned earlier on and it was
4 called the Consultative Committee under Dr Aitken who was
5 himself at the Otago Medical School and he was also the
6 father of a disabled child.

7 But instead of the - instead of what the parents
8 want, which was community facilities, schools, occupation
9 centres and all those sorts of things, what happened
10 instead is that the Aitken Report recommended expanding
11 the institutions and for parents to send their children
12 there by the age of 5. And then we had this huge
13 expansion of institutionalisation over the next two
14 decades, even though in 1959 another report by Dr Burns
15 of the British Medical Association supported the parents
16 and their call for community facilities but it was hard
17 to turn the juggernaut around.

18 The 1964 National Film Unit documentary 'One in a
19 Thousand' I mentioned earlier, it shows well dressed
20 children participating in a variety of interesting
21 activities at Kimberley, although the voiceover is
22 chillingly ableist. However, this official view
23 contradicts that of Robert Martin who was at Kimberley
24 around that time. His memory is of, despite some good
25 staff, boredom, rigid routines, lack of education, denial
26 of identity, including clothes, possessions and culture
27 and neglect and frequent abuse.

28 This documentary illustrates how easy it was to spin
29 a good news story, to reassure parents and the public and
30 why even official visitors didn't notice carefully hidden
31 abuse.

32 Years later, the Confidential Forum for Former
33 Inpatients of Psychiatric Hospitals heard about the 'back
34 wards' of the institutions as places of horror and threat

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1 of adults and children living together in distressing
2 conditions and unconsented sterilisations.

3 So, by the 1970s, thousands of children, young
4 people and adults, were locked up in a network of
5 psychopaedic and psychiatric hospitals, residential
6 schools and youth justice homes throughout the country.

7 Robert Martin's biography, 'Becoming a Person',
8 which is here, and he will be speaking next week, he has
9 more valuable insights into institutionalisation. He
10 will talk himself but his experience, soon after he was
11 born in 1957 he was labelled retarded and he was sent to
12 Kimberley. He also had time in other institutions and
13 also extremely abusive foster care. And also had a stint
14 in Lake Alice.

15 Robert remembered some kind staff at the places he
16 was sent to but the harsh institution life was frequently
17 abusive. But, as he says, at least he could walk, talk
18 and fight back, unlike some of the others.

19 And when Robert reached 15, the State tossed the
12.19 20 angry teenager out of care. He had been denied not only
21 human rights but culture and identity.

22 In 2009, a 60 Minutes documentary called Shock
23 Treatment told the sad story of a group of unlucky girls
24 placed in residential State care who were suddenly all
25 apparently diagnosed with epilepsy and put on an
26 experimental cocktail of strong drugs with ECT as
27 punishment, all without their consent or even knowledge.
28 This was at Fareham House in the Wairarapa. Eventually
29 the management changed and treatment ceased but the
12.20 30 long-term effects remained severe for many of them, as
31 reported in the documentary.

32 There are also rumours of unconsented LSD trials at
33 Ngawhatu. I would not be surprised as institutionalised
34 children and adults have long been used for drug and

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1 medical experimentation, such as with polio in the US.
2 Unconsented cadavers from Seacliff were provided to the
3 Otago Medical School. It would be really good if the
4 Commission could research these rumours of egregious
5 breaches of medical ethics.

6 Meanwhile, truant or misbehaving children, mostly
7 boys and often Maori, as young as 7 and many having what
8 we would probably now recognise as learning or
9 neurological disabilities could be picked up by
10.21 10 authorities and deposited in one of the many children
11 homes such as Epuni and we've heard how that was often
12 the first step through lifelong incarceration.

13 But many disabled children did not live long enough
14 to become adults.

15 While doing my PhD research, I heard from an elderly
16 man who told me his sister who was Down syndrome was sent
17 away and not spoken about because if anyone found out
18 about the family's bad genes other family members would
19 not be able to find partners. A woman told me that those
12.22 20 with autistic children faced significant discrimination
21 as popular theories blamed refrigerator mothers for their
22 autism. They found it hard to get community acceptance
23 or fundraise.

24 The deinstitutionalisation movement started in the
25 1970s but only in 2006 did Kimberley, the last one, close
26 after a march on Parliament.

27 I urge people to visit the old Porirua Hospital
28 villa which is now a museum. There are displays of
29 innovative "treatments" such as ECT and insulin. The
12.22 30 seclusion room where young people were often held and a
31 straightjacket are still terrifying. I hear it's under
32 threat of closure, something else that the Royal
33 Commission should stop as it provides vital evidence of
34 what happened.

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1 Now, the next part of my evidence is on Maori
2 Pasifika but it's not an area of expertise of mine and
3 others have covered it and will do so. Anecdotally,
4 Maori children were disproportionately affected by
5 disability abuse, we know that. There is also a need for
6 more research about disabled Pasifika children in the
7 institutions.

8 Changing tact a bit, getting onto what constitutes
9 abuse that has already been mentioned. It takes many
10 forms and it includes physical, any behaviour threatening
11 physical safety or bodily integrity. Sexual, anything
12 non-consensual, illegal or inappropriate. Emotional or
13 psychological, including threats or bullying or
14 undermining.

15 Segregation from friends or partners.

16 Neglect, such as lack of access to medical
17 treatment.

18 Control and restraint, including medical restraint
19 or medical experimentation.

20 Financial, stealing or withholding money.

21 Cultural, exclusion from ethnic family or culture.

22 Demeaning, for example photographs of
23 institutionalised residents without their consent.

24 Witnessing abuse and silencing, so that victims are
25 unable or unwilling to complain.

26 A 2013 report by Michael Roguski provided evidence
27 of abuse of disabled people living in the community. So,
28 not in institutions, either in residential homes or
29 similar. This is just one area. He examined disability
30 support in the Gisborne area and talked to disabled
31 people, families and advocates. He found a number of
32 structural issues including:

33 A low level of societal awareness of disability
34 abuse;

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1 A variety of silencing processes;
2 A lack of appropriate monitoring;
3 Poor management practices;
4 Inadequate reporting;
5 Inadequate legislation including no protection or
6 support for the disabled person during an investigation
7 of abuse.

8 The silencing he found was particularly worrying.
9 For the disabled person, it meant pressure not to report,
10 not to report the abuse because for various reasons. And
11 also, the sad reality that an abusive care worker is
12 better than no care worker.

13 Disabled people feeling they were unworthy of good
14 care or deserving of abuse.

15 Normalisation of poor treatment.

16 Difficulties in communication, for example the
17 disabled person non-verbal or minimally verbal.

18 Undermining of the disabled person's testimony.

19 And collusion by authorities to protect the
12.27 20 perpetrator.

21 A 2012 survey of disability abuse in California
22 showed a similar picture. The authors of that survey
23 conclude that abuse is prevalent and pervasive and
24 happens repeatedly to victims with all kinds of
25 disabilities.

26 I would like the Royal Commission to recommend a
27 similar New Zealand wide survey in which disabled people
28 receiving services are free to answer anonymously with
29 independent support without providers present.

12.28 30 Some recent examples, this is post again, out of the
31 post institutions. This is hard. This is Ashley. The
32 1992 Mental Health (Compulsory Care and Assessment) Act
33 was supposed to end abuse with new processes. Instead,
34 the Act provided a new catchall diagnosis of mental

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1 disorder which was the justification for locking up a
2 young autistic man, Ashley Peacock, for over a decade.
3 After many long stretches of months in seclusion,
4 mysterious injuries, including the one in the photo, and
5 years and years of parental advocacy, he was finally
6 released into community care in 2018. Media attention
7 got him out but the years of incarceration have had a
8 negative effect on him and his parents.

9 But he's not an isolated case. I have a friend who
10 has a high needs daughter and she's often told even by
11 family members to put her daughter in an institution.
12 Not that there are any institutions or even any respite
13 care that are appropriate for her. And her mother wants
14 to keep her at home. So, untrained, unskilled carers
15 come regularly into the house and I have seen and heard
16 from her how some bring demeaning ableist attitudes.
17 One-to-one care can mean allegedly no spoken interaction,
18 locking the young woman in one room for hours without
19 food, drink or toilet breaks. Deleting her favourite
20 television programs. Taking her possessions. And even
21 hitting her dog.

22 So, that's recent. Nothing in so-called disability
23 support shocks me now or in the past.

24 Disabled people are still suffering abuse despite a
25 whole series of reports. We have a 2008 Select Committee
26 Report, a big long Inquiry for a couple of years. We had
27 a 2013 Ministry of Health report, the Russell report. We
28 have ongoing media stories, Health and Disability
29 Commission investigations. A 2011 Ministry of Health
30 report, reported life expectancy for people with
31 intellectual and learning disability was about 20 years
32 less than for those without. The Donald Beasley
33 Institute did a whole lot of work around 2003 to have An
34 Ordinary Life Report about how we could improve things.

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1 So, New Zealand, as it's obvious, has a much longer
2 history of disability abuse than just 1950-1999.

3 A fully restorative approach, including an official
4 and unconditional apology from the top, may help heal and
5 ensure no more are harmed. This is a good example of an
6 apology. It is the 2001 from Prime Minister Helen Clark
7 to some of the victims of abuse at Lake Alice and what
8 she said was, "Whatever the legal rights and wrongs of
9 the matter, and whatever the state of medical practice at
10 the time, our government considers that what occurred to
11 these young people was unacceptable by any standard, in
12 particular the inappropriate use of electric shocks and
13 injections".

14 And what I like about this one is it challenges the
15 common arguments here that what happened was norm for the
16 time, well it wasn't. And it happened a long time ago so
17 it's no longer relevant. It's still relevant.

18 I will just skip over the next part which is the
19 best practice for an official apology but I don't think
20 we've quite got to that point yet. And the restorative
21 practices are only just beginning.

22 So what I'd like to talk a bit more about is how
23 care can be transformed and what for me is - I want the
24 one of ableism. What we have to do is address ableism.
25 Disability academic, Fiona Campbell, she's described
26 ableism. She says it projects a particular kind of self
27 and body as essential to be fully human, one that is fit,
28 active and healthy. Disability is thus cast as a
29 diminished state of being human and should the
30 opportunity present itself, be ameliorated, cured or
31 eliminated.

32 Under these circumstances, persons with severe
33 impairments often trigger responses such as fear,
34 revolution or confusion and assumptions that the disabled

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1 person's life must be terrible and not worth living.

2 And you can see in that description, it's really
3 eugenics, that's where it's come from and also, yeah, the
4 other thing we need is some urgent attention to workforce
5 development.

6 I want to say a bit about structural and systemic
7 ableism, just a couple of examples, because it is - any
8 data about deprivation or social, economic, disabled
9 people are the bottom. So much of our physical,
10 political or other information environments are not
11 accessible to everybody.

12 Any support that is out there is rationed, whether
13 it's in schools or in the community, everything is
14 rationed. It's not there as a right.

15 And there's a lack of interest and representation of
16 disability anywhere. If it's, theoretically, 24% of
17 New Zealanders identify as having a long-term impairment,
18 where are they? Where are they in all these processes?
19 We don't have data, apart from that. The census
12.36 20 questions have changed, so we're going to get worse
21 information. We disrespect disability everywhere and
22 that is structural systemic ableism.

23 It's not for lack of trying particularly by
24 disability advocates themselves.

25 We have the aspirational, the New Zealand Disability
26 Strategy 2001 which "Underpinning the New Zealand
27 disability strategy is a vision of a fully inclusive
28 society. New Zealand will be inclusive when people with
29 impairments can say they live in:

12.36 30 'A society that highly values our lives and
31 continually enhances our full participation'".

32 The UN Convention on the Rights of Persons with
33 Disabilities, which New Zealand has ratified in 2008, you
34 can't read these but here are some of the articles. The

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1 Convention describes what these look like in real life.
2 I think we would be pushed to actually meet any of them.
3 Maybe we've had attempts at some of them. So, I think we
4 really need that apology from the top for this whole over
5 a century of eugenic state policies targeting disabled
6 children, young people and adults. It was wrong, it was
7 unjust and its legacy lingers in ongoing reports of
8 disability, discrimination and abuse.

9 I want to leave the last word to Robert who is a
10 hero. This is a picture of him at the United Nations
11 during the drafting of the Convention on the Rights of
12 Persons with Disabilities where he spoke on behalf of
13 Inclusion International where I think he was a Vice
14 President. His quote is:

15 "Though it's great that New Zealand closed its last
16 institution (Kimberley Centre), being institutionalised
17 is not just about the buildings, the bricks and mortar.
18 It is also about values, beliefs, actions and activities.
19 It's about the way things are done, the decisions that
20 are made, who makes them and who has the control. In
21 New Zealand, we still need to work hard to ensure that
22 people with disabilities do not continue to be
23 institutionalised even though they live in community
24 settings."

25 So, I'll stop there, thank you.

26 **MS JANES:** I have some additional questions for
27 Dr Stace.

28 I don't know if you want to take a break now,
29 we are just about at 90 minutes or we can continue?

30 **CHAIR:** I think probably we should take a break so as to
31 keep within the 90 minutes that we set out and we
32 will return a bit early after lunch has occurred.

33 **MS JANES:** Thank you, Sir.
34

1 **Hearing adjourned from 12.40 p.m. until 2.00 p.m.**

2

3 **MS JANES:**

4 Q. Dr Stace, going back to first principles, is there a
5 shared understanding of disability? Can you describe
6 that?

7 A. A shared understanding, we have definitions but the
8 language has definitely changed over time. I would say
9 there probably isn't a shared understanding. The
14.03 10 language has changed a lot over time. In New Zealand, we
11 use the definition from the disability strategy that I
12 mentioned about that people are disabled by their
13 environments and attitudes, so disability is political
14 basically. The UN Convention using persons with
15 disabilities because that's people first language, so
16 that's another way. A shared understanding, there are a
17 lot of different diagnoses and they change over time.

18 So, yes, it's quite hard at this time and place, we
19 probably have quite different understandings than we
14.03 20 would have had in 1950 what disability is and there's new
21 diagnoses happening all the time.

22 Q. And would a shared understanding or definition assist
23 work in the - would a shared understanding or definition
24 of disability assist in research and understanding of
25 disability?

26 A. Definitely social model, which is the disabled person,
27 the person disabled by their environment, that is really
28 our official New Zealand interpretation.

29 The other model, what it replaced was the individual
14.04 30 model, where disability or impairment was located in the
31 individual and was an individual problem.

32 So, the social model approach, regardless really of
33 the language used, is what we really need so people are
34 not individually deficient. Society is deficient but not

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1 including them.

2 Q. You speak quite a lot about eugenics in your evidence, is
3 there still a residue or impact in society today?

4 A. Yes, definitely. I heard Boris Johnson say the other day
5 that poverty is caused by bad genes, we hear a lot of the
6 language of certain groups not allowed to breed on talk-
7 back radio. That sort of language is quite common
8 around the place, certain groups. The hints are they are
9 genetically a problem, it is the ableist attitudes and
14.05 10 ableism is eugenics that I mentioned before being
11 widespread that really provides that basis for eugenics,
12 or whatever we call it, stills thrive in various
13 attitudes and just basic things like disability support
14 is rationed, so there's nothing as of right really.

15 So, disabled people using the social model of
16 disability definition are still seen as not fully human
17 basically, and that's a eugenic attitude.

18 Q. So, moving from that to education at paragraph 50 of your
19 brief, you talk about abuse and neglect in education. Is
14.06 20 there anything that you would like to say further about
21 that? And is there an article that you would like to
22 produce as an exhibit?

23 A. I did co-write an article for the Policy Quarterly a few
24 years ago about special education and how schools are
25 almost penalised financially and otherwise for being
26 inclusive. So, although we have a 1989 Education Act,
27 section 8, which legislates for all children to be able
28 to attend their local school from 5-19 years, full day,
29 it is the reality for many, many children that's not the
14.07 30 reality. They are either persuaded to go to another
31 school down the road or they're only allowed to attend a
32 couple of hours a day. But the schools that are trying
33 hard to be inclusive, it costs more to support those
34 children properly than the funding allows, so we have

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1 these magnet schools, so-called, because they've got a
2 nice inclusive environment and philosophy of belonging
3 but it's hard for a lot of those schools. It's easier
4 for schools to quietly persuade families to enrol their
5 family in another school. That's so widespread, there's
6 social media, Facebook pages of parents every day facing
7 discrimination against their children.

8 Q. Thank you. Sir, if I may produce as an exhibit,
9 "Education is for everyone unless you are special", as
14.08 10 Exhibit 8.

11 **Document entitled "Education is for everyone unless**
12 **you are special" produced as Exhibit 8**

13 You spoke about education and seclusion rooms, are
14 they still a part of the system?

15 A. After families finding that schools were using them, I
16 think it was about three years ago, and again the media
17 exposed that, the law was changed I think early in 2017,
18 maybe 2016, to outlaw seclusion rooms as such. Also,
19 there were a whole lot of new guidelines brought in about
14.09 20 what you could do about restraint.

21 So, theoretically we have no seclusion rooms. I
22 suspect that time-out rooms of all sorts of styles are
23 still being used. And I note some teachers are
24 complaining about the restraint guidelines as being too
25 prescriptive.

26 So, I think all these things, there needs to be a
27 lot more transparency in schools about what's actually
28 happening, ERO to look a bit deeper, because the
29 seclusion rooms in those schools were there for years
14.10 30 without anybody knowing or saying that they were there.
31 So, I think with all these things, ongoing vigilance is
32 required.

33 And I think it was quite sad that in, I think I'm
34 right about this, in the seclusion rooms, they were

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1 mainly in the special schools already, so we already have
2 the schools where the children are almost, they're not in
3 their local communities, they go somewhere else for a
4 special environment and that's where the seclusion rooms
5 mainly turned up. So, again, it's vigilance, inclusion,
6 transparency, it's really important to not let those
7 things creep back in.

8 Q. And following on from those recommendations or
9 suggestions, are there any other changes that you think
14.10 10 New Zealand should be considering in terms of disabled
11 persons' inclusion in the community and to prevent abuse?

12 A. In not just education?

13 Q. No.

14 A. There's just so many ways it can be approached. I mean,
15 you know, it's again - it's resourcing, it's having a
16 system whereby parents or - you know, parents are pretty
17 savvy, they know when there is something different about
18 their children quite often and they seek help. Huge
19 waiting lists if there is any help. Everything is
14.11 20 rationed.

21 So, it's a slow, slow process to get the support, if
22 support even exists.

23 So, I would suggest some system whereby children,
24 when they have something identified even before the
25 diagnosis because a diagnosis can take ages, parents
26 know, they know, they need extra help with their child.
27 It might not be something that's actually clinically
28 diagnosed but they need help with their child. Just like
29 the Karitane nurses when mothers got a bit stressed,
14.12 30 there needs to be something in the community that can
31 help with families going through that stress. And if
32 it's - if the child does end up with some kind of
33 diagnosis, some wraparound system that probably goes with
34 that child for their whole life throughout all the

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1 transitions, change the personnel but something that is
2 unique to that child, not fashioned. You know, there's
3 been some ideas and principles and attempts at doing
4 these things over the years but they don't seem to last
5 or be funded properly.

6 Q. I think we just need to slow down a little bit. Thank
7 you for that.

8 And you've heard that Judge Carolyn Henwood spoke on
9 Tuesday about how the Confidential Listening Assistance
10.13 10 Service had tried to reach out to include the disabled
11 community and felt they had failed, not many stories had
12 been heard. Do you have any suggestions that this Royal
13 Commission could consider in light of trying to be
14 inclusive?

15 A. Yes. Considering that a lot of the people who were
16 experiencing abuse in the psychopaedic hospitals are no
17 longer with us, we really have to make an effort to find
18 those who are survivors and still with us.

19 Realistically, that could be a group home of
10.13 20 Kimberley ex-residents, maybe minimally verbal, living in
21 a place where their provider may know nothing about their
22 past. So, it's no good just telling provider
23 organisations this Royal Commission exists. It has to be
24 something that goes and finds people, takes time to build
25 that relationship of knowledge and trust, to get the
26 stories in an environment that suits them.

27 And I think there's some examples in the
28 Extraordinary Stories book by Spectrum Care a few years
29 ago that Brigit referred to. They did actually find some
10.14 30 stories, even people who they had no sort of history.
31 There is an example in the Templeton work of Jabbot, I
32 think his name is, who was one of the survivors from
33 Templeton who is very able to tell his story. If
34 somebody went to Christchurch, went to his group home,

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1 built a relationship, he would have a wealth of
2 information to tell but it has to be person-centered,
3 suit him, through intermediaries. It can be done but
4 it's time consuming for each one but it really needs to
5 be done, otherwise they just won't go and knock on the
6 door of the building in Featherston and say "I'm here,
7 listen".

8 Q. Thank you. A question, you've talked about some things
9 that have happened post-institutionalisation but if you
10 were to characterise the state of the nation now, what
11 would you say?

12 A. We have had lots of good intentions. We've had endless,
13 endless reports into the health system and education
14 system, things come and go. There is a good - I'm quite
15 heartened by the latest programme under development, it
16 is a prototype called Mana Whakahai in Mid Central Health
17 and it's based on the enabling good lives principles
18 developed by disabled people themselves a few years ago.
19 It's governed and run by disabled people. Their trouble
20 is though that once you provide something really good, a
21 lot more people come out of the woodwork and want it, so
22 therefore you have a funding constraint, it falls over
23 again, and it's only one area. It might be years til
24 it's rolled out but there are good intentions and there
25 are good people trying to do good things but it really
26 has to be systemic and wraparound and be individual.

27 Q. And a final area of my questioning is, at paragraph 3 of
28 your brief you talk about having had two contracts with
29 the Human Rights Commission in 2013 and 2014. Can you
30 elaborate on what they involved and any reports that
31 emanated from that work?

32 A. I think there's been concern in the Human Rights
33 Commission for decades about this work and I think Ros
34 Noonan is coming to speak next week and she was involved

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1 as Commissioner for one of those reports. It didn't ever
2 get published.

3 Then in 2013, there was - that had all come under
4 OPCAP, so it didn't come under UCRPD. In the business
5 plan 2013, there was one line saying, "Ensure there is a
6 review of historic abuse in State care to inform State
7 care and welfare services delivered in New Zealand today"
8 and I had a small part-time job more or less doing a
9 stocktake of what had gone on, what the state of
10.18 10 everything was. There was an idea that there were a
11 whole lot of files that MSD had that could be looked at
12 to say systemic abuse and that was the initial thing but
13 I think that was ruled out because we knew that was
14 abuse. And too, the abusers won't say in the file I
15 abused X last night, write it down, for somebody in
16 30 years to find.

17 So, I did a bit of a stocktake. I started with what
18 I call a kaitiaki group of Robert Martin, a survivor,
19 Robin Hunt who was an ex-Commissioner, who else was on
14.18 20 that? Anyhow, it was - Anne Hill on was that too. We
21 decided what we could do in a very short time. And we
22 had a round table in June 2014 where all sorts of people
23 were invited, government agencies, individuals who were
24 working in the area, psychiatrists who had been working,
25 lawyers. We had this great round table of about 50
26 people and the idea was to spark something because that
27 contract was ending, to spark something that would be
28 ongoing.

29 So, there was - yeah, it wasn't popular with the
14.19 30 government, shall I say that. So, yeah, nothing much
31 happened afterwards.

32 Q. And that report that you've talked about which was
33 "Project: Ensure there is a review of historic abuse in
34 State care, to inform State care and welfare services

1 delivered in New Zealand today", could we please produce
2 that as an exhibit which will be Exhibit 9 but I will
3 take Dr Stace through a couple of the issues before
4 turning you over to the Commissioners.

5 **Report produced as Exhibit 9**

6 In that report -

7 **MS JANES:** Would the Commissioners like a hard copy?

8 **CHAIR:** Yes, please. (Copy of report handed to
9 Commissioners).

10 **MS JANES:**

11 Q. Just very briefly, just to highlight some aspects of the
12 report. So, the first thing that you did in your report
13 was to set out a timeline from the 1990s through to
14 October 2013 about actions that had been taken in
15 relation to historic abuse claims?

16 A. Yes.

17 Q. And you then have some conclusions on page 5 of your
18 report?

19 A. Yes, they were from March 2014 and after that there are
14.21 20 just some appendices. I don't have any written material
21 after March 2014, although the round table didn't take
22 place until June.

23 Q. And can you just go through the appendices which are on
24 page 6 and outline the purpose of collecting that data?

25 A. Well, it was just to, we wanted to know, well I was
26 employed in a very part-time capacity to find out really
27 what had happened over the decades. The then Chief Human
28 Rights Commissioner had some questions about what had
29 happened and so we dug up correspondence and there were
14.22 30 various other things like the Broad report, Howard
31 Broad's report had been useful, various emails from
32 people who had been - I mean, this work has been, the
33 push for this work has gone on for decades, so there was
34 a long history, including in places like the Human Rights

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1 Commissioner. Am I allowed to say, really Commissioner
2 Gibson, he did a lot of work to try and get a focus on
3 historic abuse and he was at the Human Rights Commission
4 at this time.

5 Q. And the correspondence that you collected that's annexed
6 to this report, how would you characterise the views of
7 the Human Rights Commission versus those of the
8 government of the day?

9 A. Well, there is a letter there from the Attorney-General
10 who is quite disrespectful of the earlier work that had
11 been done. I mean, yes, I don't know how the government
12 works but I think it's quite hard to go on with a project
13 once you've been almost shutdown by your superiors.

14 Q. And can you just describe what involvement, if any, you
15 had subsequent to producing this document?

16 A. When I finished with this contract, I didn't really,
17 apart from continuing to promote the work in this area, I
18 met quite a few people as a result of that round table
19 and worked out, you know, what they were doing and their
20 interests. So, I sort of had some informal conversations
21 with people but, from then on, it was just a push for
22 advocacy for a Committee, a Royal Commission, something
23 to look at historic abuse. So, it was constant, the push
24 for this, as it had been for decades and I think it was
25 announced actually by Jacinda Ardern at Lizzie Stanley's
26 book launch in 2015, she said if they were finally in
27 government they would have one. The government of the
28 day thought what was already there was sufficient, there
29 were no new cases, there wasn't Legal Aid but the
30 processes were existing already, it wasn't needed to do
31 anything. They did extend CLAS for another couple of
32 years but they took money from the Ministry of Health to
33 do that.

34 Q. And the view that you've just outlined, that everything

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1 was fine and working well, is captured in the documents
2 in that report?

3 A. Yes.

4 **MS JANES:** I would like for an interim section 15 order
5 for this report, primarily because there is some
6 litigation that is named. I don't know the status
7 of whether there are any suppression orders that
8 may attach to that. So, on balance of caution, I
9 would ask that any litigation or proceedings' names
10 are given a non-publication order?

14.26

11 There are also names of staff members who are not in
12 senior roles, as I understand it, within the
13 organisations and so would not have had an expectation
14 that they would be named in public, and so I would also
15 ask for a non-publication order for staff members in
16 non-senior roles within the organisations mentioned
17 throughout the report.

18 **CHAIR:** Thank you. I have been looking at the document
19 as Dr Stace has been speaking and referring to it,
20 and I can see the thrust of the application that
21 you make. Can I ask if there is any objection to a
22 section 15 order being made by the Commission?
23 There isn't. Well, in that event - my colleague,
24 Judge Shaw, has just intimated to me a slight
25 reservation about the term "not senior roles". It
26 seems to be a rather broad and vague definition.
27 Is there any other formulation of words that would
28 cover the position?

14.26

29 **MS JANES:** What the order seeks to do is one is not
30 seeking non-publication of people in
31 Chief Executive or senior leadership roles. So,
32 people within the Claims Unit or operational roles
33 would not expect - normally an OIA application,
34 their names are redacted.

14.27

1 **COMMISSIONER SHAW:** If it I could make it clear. It's
2 just being able to, I get the point and I support
3 the notion of non-publication to protect those
4 people. It's just the way it's described. You've
5 just said it, I think, people other than
6 Chief Executive and what was the other?

7 **MS JANES:** Senior leadership roles.

8 **CHAIR:** That seems to cover it in a better way.

9 **MS JANES:** Thank you.

14.28 10 **CHAIR:** Having regard to the application that you make,
11 can I enter into the record as follows:

12 The Inquiry has been asked by Counsel Assisting to
13 make an interim order under section 15 of the Inquiries
14 Act 2013 to prohibit publication of the names of legal
15 proceedings. This is to avoid any inadvertent breach of
16 suppression or other orders, as well as the names of any
17 staff members to protect their privacy where the roles
18 they are or were employed in were other than that of
19 Chief Executive or senior leadership roles. In other
14.29 20 words, being people who had a reasonable expectation that
21 they would not be publically named.

22 **MS JANES:** I am obliged, Sir, thank you.

23 **CHAIR:** Having considered the application and reviewed
24 the matters the Inquiry ought to consider under
25 section 15(2) of the Act though, the order that you
26 seek is made.

27 **MS JANES:** I have no further questions.

28 **CHAIR:** I am now going to, first of all, ask counsel
29 whether anyone wishes to exercise a right of
14.30 30 cross-examination of Dr Stace? I will then ask my
31 colleagues if there are any questions. And in the
32 middle, there is a little thing that I would like
33 to say. First of all, counsel? There are no
34 questions.

1 The thing that I wish to say, Dr Stace, is that in
2 addition to your brief which runs to 22 pages, there is
3 what I consider to be a prestigious bibliography of
4 material which itself runs to five pages. I just want to
5 record in public the usefulness that that material is and
6 will be for the Royal Commission as it considers your
7 evidence, along with other matters, and I want to thank
8 you for that.

9 A. Thank you.

14.31 10 **CHAIR:** Can I then ask if any of my colleagues wishes to
11 ask you any questions?

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HILARY STACE

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QUESTIONED BY COMMISSIONERS

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COMMISSIONER GIBSON: Kia ora, Dr Stace. Thank you for

7

the amazing presentation. My first question is

8

about, I suppose, the current cultural backdrop,

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whether it facilitates abuse and neglect, and just

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comparing, I suppose racism and ableism falling out

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of something historically eugenics and I think

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everybody understands and finds racism

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appropriately abhorrent. Ableism, I suppose,

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manifests itself in different ways.

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To what extent should we find it abhorrent and to

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what extent is it pervasive today?

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A. Well, discrimination is bad whatever you label it and

18

whatever the target group is, and there's often, you

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know, racism and ableism will go together.

14.32 20

I don't think there's a big understanding of

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ableism. I don't think people reflect on maybe some

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ableist attitudes that we all have. I think, yeah, I

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just think it's all abhorrent because all those

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discriminations, isms, see other humans as not fully

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human, not fully deserving of rights, agency, dignity,

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all those sorts of things. I am not sure if that's what

27

you meant.

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COMMISSIONER GIBSON: Yes, thanks. I know some of the

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things that have been happening in Australia, I'm

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looking for your comment on those. They've

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undergone quite a huge transformation of their

32

support system, a huge increase in resources. To

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what extent does New Zealand require that or not to

34

ensure people are safe from abuse and neglect in

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1 care?

2 A. Do you mean - sorry?

3 **COMMISSIONER GIBSON:** That first.

4 A. Do you mean the NDIS?

5 **COMMISSIONER GIBSON:** Yes.

6 A. The NDIS, their ideas came from their government I guest
7 about a decade ago and we thought how wonderful, they
8 came to New Zealand and we all talked to them. The
9 trouble with it, which this was going to be sort of an
10 ACC-type system with levies, I think. But the trouble is
11 each State could make their own priorities and do it
12 their own way. As time has gone on, the eligibility
13 criteria has got much tougher, it's harder, it doesn't do
14 under 8 year olds which seems ridiculous. And there's I
15 think widespread disappointment that the promise hasn't
16 met much - I mean, some people, okay, but actually it's
17 still flawed and it's because it's subject to rationing
18 and funding again, which is what the problem is.

19 I think personally what I would like to see in
14.34 20 New Zealand, is some alignment of ACC, Ministry of Health
21 and Ministry of Social Development to have one universal
22 equitable fair system of disability support and income
23 support. And I think we could lead the world in doing
24 that.

25 So, yeah, the NDIS, great idea. A bit of a
26 disappointment.

27 **COMMISSIONER GIBSON:** Secondly, I am aware Australia had
28 institutional responses to the Child Sexual Abuse
29 Commission, much bigger resource-wise than what
14.35 30 we're doing here, \$373 million. One of the
31 outcomes of that was increase awareness of sexual
32 abuse of children wasn't appreciated prior to that.
33 A few years down the track, there's an even bigger
34 Inquiry in terms of disability, violence abuse,

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1 exploitation and neglect, \$AUS427 million, on a
2 scale bigger than the child sexual abuse. What
3 lessons do you take from what's gone on in
4 Australia in the last years about violence and
5 abuse against disabled people?

6 A. The last Royal Commission, the people, some of them came
7 to New Zealand was it last year, and told us about it.
8 And the man I talked to said they didn't really think
9 about disability when they started talking about sexual
10 abuse. But then one volume out of whatever they had, 40
11 volumes, was on disability and they thought there's a
12 problem there. Well, we know that! I really like the
13 one they're doing now. They've just started. They're
14 live streaming some of the hearings, they've only just
15 started doing some public hearings. I really, really
16 like that focus on disability only because if nothing
17 else, no reflection or disrespect to anybody, we know
18 disability is sidelined, it's not interesting, people
19 don't really relate to it, they feel uncomfortable,
20 unless there is a primary focus on disability and
21 disability abuse, it is always at risk of being
22 sidelined. Abuse, support for disabled kids, support for
23 disabled adults, support for disabled aged people, it's
24 always going to be sidelined unless there is a primary
25 focus, unless people are really, really concerned to make
26 it a strong focus of whatever work is underway.

27 **COMMISSIONER GIBSON:** Thank you.

28 **COMMISSIONER ALOFIVAE:** Good afternoon, Dr Stace, and
29 thank you very much for the considered and
30 meticulous way in which you've presented your
31 evidence.

32 My question really arises out of what really struck
33 me was the systemic issues that constantly compound and
34 actually leads to the deterioration really of the journey

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1 of the disabled persons through the system.

2 Earlier on in the week, Judge Carolyn Henwood spoke
3 about a separate independent entity or an authority of
4 some sort that would actually - that could actually
5 receive the complaints specific to that, so that people
6 could feel they could come forward to actually kind of
7 get some grievance or to get some redress around some of
8 those grievances. And I like what you're saying about
9 the lack of alignment because that's what continues to
10 compound. Any views on that?

11 A. Yes. When we had the Select Committee 2008, I think one
12 of the recommendations was for a Disability Commissioner
13 which would actually do some of those things. I remember
14 the Cartwright Inquiry of the '80s and we thought hooray,
15 the Health and Disability Commission is going to be the
16 answer. Well, two years to get a - it's not working as
17 we thought it might. Again, I think some sort of, Mm, a
18 Disability Commissioner as well as the one on the Human
19 Rights Commission, so one with its own office that can do
20 investigations, that can hold government to account,
21 independent of the Office of Parliament, all those
22 things, I would like. And it was a recommendation in
23 2008, and it said if other things don't work we'll look
24 at it again, I think it might be time to look at it
25 again.

26 **COMMISSIONER ALOFIVAE:** Thank you.

27 **CHAIR:** Thank you. I don't have any further questions
28 of you myself but I now ask my colleagues, Judge
29 Shaw and then Dr Erueti?

14.39 30 **COMMISSIONER SHAW:** Thank you, Ms Stace, I am very
31 grateful for your evidence but I have no other
32 questions for you.

33 **COMMISSIONER ERUETI:** I was going to ask the same
34 question but I have another question.

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1 I wanted to, thinking in the post-institutional
2 environment about are we still seeing the features of
3 institutionalisation in effect? I wondered whether
4 there's been an increased burden or responsibility, is a
5 better way of putting it, placed on whanau and family?
6 Could you just describe for me that?

7 A. I think there is. I think any parent or family or whanau
8 trying to support a child, particularly one who might
9 have quite high needs, is really, really hard. There are
10 different mechanisms, you can be a fund holder, but the
11 work really needs some concentration on the workforce,
12 and the workforce has to be very professional, it has to
13 have high status which it doesn't have now. It has to be
14 a career, so you can be whatever you call it, personal
15 assistant or carer. It needs to be something that people
16 want to do and has career development, Code of Ethics,
17 good union, all those sorts of things, and highly
18 professional. I think that would be a start.

19 So that, when parents need support to have their
20 child at home or they are in a residential placement of
21 some kind, they can have confidence that that child, who
22 is an adult, who will be an adult when they die, which is
23 a huge worry for parents of my generation, that they can
24 have confidence there is that professionalism of the
25 career of disability support worker, so you don't have to
26 be constantly vigilant. You don't have to constantly
27 worry about, you know, are they getting fed? Do they go
28 and do anything in the community? Are they just getting
29 barely babysat and that's all? You know, I think a
30 workforce, a huge strong focus on workforce would be a
31 really good thing to do and I don't think anybody is
32 actually doing it. I mean, of all the other work
33 programs, but that I think would help because there are a
34 lot of people living with their parents or not too far

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1 away. We don't really have - we hardly have any
2 residential options in the old institution sense, there's
3 a few but not many, mostly people living in group homes
4 or one-on-one homes, single person homes.

5 **COMMISSIONER ERUETI:** One last question about the
6 redress schemes, Dr Stace. I wonder about
7 accessibility of people with disabilities to the
8 redress schemes offered by MSD, Ministry of Health
9 and Ministry of Education. You did mention
10 something earlier about the need for a Commissioner
11 on Disabilities and perhaps that could provide that
12 service?

13 A. Do you mean going through the current processes that you
14 can go through, through the -

15 **COMMISSIONER ERUETI:** Yes, through the MSD historical
16 claims.

17 A. I think education.

18 **COMMISSIONER ERUETI:** And health?

19 A. Yes. Certainly, support is required, yeah, I think
20 that's just a matter of people won't know that they can
21 do. People don't know that their experience might have
22 been abusive because it was the norm. Families, we need
23 to, and this is the thing I want to say, I wish the Royal
24 Commission hears from staff from families. Survivors are
25 important but in disability a lot of them are no longer
26 with us but there are still scarred families, still staff
27 members horrified at what they saw and had to do. I
28 think you have expertise here at the Commission to know
29 how to do that in a very respectful way. It is a matter
30 of finding people, walking with them, building a
31 relationship and going through that process.

32 **COMMISSIONER ERUETI:** Thank you.

33 **CHAIR:** Thank you, Dr Stace, thank you for your evidence
34 and your willingness to answer questions.

1 A. Thank you.

2 **MS JANES:** Thank you, Dr Stace, you are excused.

3 Commissioners, we now enter a slightly
4 challenging phase, we're going to see how we go
5 with our next witness who is Mary O'Hagan. She's
6 in Australia. We have done some road testing on
7 the technology with some speed bumps, so with your
8 indulgence, we will start the process, if it all
9 collapses we may adjourn, with your permission, for
10 5 minutes and see if we can resurrect things. So,
11 we're in your hands and the technology's hands.

12 **CHAIR:** My colleagues and I discussed what was in front
13 of everyone at the luncheon adjournment and the way
14 that you suggest seems to be the sensible way.
15 Let's try and make the hook up and we will work
16 with whatever emerges, thank you.

17 **MS JANES:** Thank you very much. If the worse happens,
18 this witness can always be recalled at a later
19 stage, so the evidence is not lost to the
20 Commission.

21 **CHAIR:** Thank you.

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