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
Date:	13 July 2022

TRANSCRIPT OF PROCEEDINGS

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Hearing opens with karakia tīmatanga and Ka Waiata by Ngāti Whātua Ōrākei

[9.35 am]

CHAIR: Nau mai piki mai ki tēnei hui, i tēnei rā. Tēnei te mihi, tēnei te mihi, tēnei te mihi ki a koutou katoa. Good morning Ms Thomas.

MS THOMAS: Tēnā koutou katoa. This morning, Madam Chair, we are starting with the first witness, Mr Ross Clark, who you can see on the screen and is able to hear us. If any of the Commissioners would like to say good morning he can hear that.

CHAIR: Good morning, Ross. Very nice to see you.

A. Lovely to see you too.

Q. Thank you so much for coming today, we're really looking forward to watching you on the video, so we can't wait to hear what you're going to tell us.

A. Right.

Q. Okay, so you just sit there and we can all watch what you're going to say, thank you.

MS THOMAS: Thank you, if we could play the pre-record video for Mr Clark.

ROSS CLARK

[Video played]

A. My name is Ross Clark and I'm 84, but when I went to Kimberley I went at the age of 19. That was young, yes. See my eyesight wasn't so bad down there. Since I've come up here it's got worse.

FEMALE SPEAKER: Yeah, and how did you end up going to Kimberley?

A. Yeah, well, my mother, it was her wishes to go down there, she said to make friends with other people. So two things were done to me, and I don't like that sort of thing.

Q. Two things at Kimberley that were done to you?

A. And they really upset me and that's really why I think, well I'm better off in a place like this, not in an institution. Never go back there again, that's for sure.

(Abuse at the bathing sheds at Kimberley.)

And then the day, that day that I was at the male staff quarters, they said "Ross, you can go home now, knock off from work." But now that's where it started. I went from the male staff quarters, I was going home that day, and somebody approached me from behind. I was actually -- there was a guy and he took me. There were two of them and they pushed me and I didn't walk out the steps. They said, "and we'll do it ourselves", and they pushed me into the swimming baths, into the, oh what do you call it? The bathing sheds. And one -- oh how awful.

And they said, "Were you sore?" Was I what. And I said -- and I got back to the villa, the staff said, "Are you all right?" I said, "No, I'm not, I'm very sore. What one of the guys did to me." "Where, at the bathing sheds at Kimberley?" "Yes." He took me in there. I told him to leave my clothes alone and he wouldn't listen. They pulled my pants down and shoved the bathing shed hose up my bottom. It hurt. Gosh. Yes, so there was no staff around at that time. I know his name too. He was a patient in villa two. And his name was [GRO-B] – he did that.

(What happened after the sexual assault at the bathing sheds?)

But I got back to the villa, a man in the villa said, "Well Ross, if you're not feeling so good you can get undressed and go to bed, I think, if you don't feel well. People doing these things, we don't like that here. Did you tell him that you don't like it?" "I told him." He was a patient from villa two, as I was then. "I don't know, it's not your fault." There was no staff around. They're not there to see what's going on.

Q. Yeah. And so what happened when you told the staff what happened to you?

A. Well, he went mad, the staff went mad. They didn't go mad at me but they went mad at the guy that did that. And of course, they sent me to Palmerston North Hospital, because way back they found a piece of metal off the hose that he put in my bottom, right in my bottom. They said, "You were lucky it didn't go right inside you. It would have really -- you would have been dead."

So they found a piece of metal, they said that the metal should not have been inside there. I can't understand why he would do a silly thing on me and he couldn't understand either. So they gave me an operation at Palmerston North Hospital and they found that there was metal inside me. Gosh.

(How did you feel after the operation?)

No, I wasn't very good after the operation, I had to rest for a long time, until I got rid of what was inside me. And that are the only two incidents that I had down there. No others.

Q. Yeah.

THOMAS: Ross, this is Thomas.

A. Yeah.

Q. Ross.

A. Yeah.

Q. About the porridge, you've eaten porridge for breakfast, do you remember that?

A. Oh yeah, that part.

(Porridge with dead flies in it, porridge with soap powder in it.)

There was a man on the staff, well, he wasn't on the staff, he was in the kitchen, h e was a kitchen-hand man, and he said Ross -- yes, I remember eating the porridge, but he said some guy that was sitting on the table with me said he was going to lift up the plate and throw it at me. "All the porridge would have gone all over you, Ross." And one of the staff was there and he saw that and he said, "How dare you do that to Ross. Look, you've really upset him."

(What were the staff like at Kimberley?)

Yeah, the staff did talk to me, but they said, "They shouldn't be like that, these people that come into an institution. You people should be left alone." I don't know.

FEMALE SPEAKER: How long do you think you stayed at Kimberley for, Ross?

A. I stayed there for about 16 years, about 23 years ago.

(Leaving Kimberley.)

I was pleased in a way, but there's one thing I left behind, you know, I left a raincoat, I left my black shoes and I had two boxes of View-Master reels and you know I never got them back. And yet my brother from Nelson has been inquiring about them. "I wonder where they'd be, Ross, they're probably in IDEA Services in Palmerston North." Oh, wherever they took them.

Q. So you never got your things back when you left?

A. I never got them back. I thought they would have - well-, they probably don't know where I live, do they – [GRO-B]. A lady brought me up from my villa, Ngaire Thompson, and that was to go to Whanganui for a holiday for a month. Well, when the four weeks was up, Tom Armstrong, he was an administrator and he said to her, "I don't know what Ross wants to do, whether he wants to go back", but I said, "No, I would like to stay, I don't want to go back." She said, "Is there any reason why?" And I said, "I don't like the place." So I don't know whether the staff liked it too well in villa two, I couldn't care less. It's my decision, nothing to do with them.

Q. So then where did you start living after that?

A. Well, I went to, I was living at [GRO-B] for seven years and they had six people, but they've all passed on, they're all gone, all the clients that were in there. Three guys and two girls passed on. And here am I still going on. And that's why I said five are gone and just left Ross just here.

And then I went to -- there were four residential home units and I went -- first of all there was Treadwell Park Hostel, I was in the hostel before going to the residential home unit. And Treadwell Park was an IHC hostel, and I couldn't tell you how many were there, but oh some naughty people.

("I did not make a complaint to the Police about what happened to me at Kimberley. I did not make a claim to ACC or ask for compensation from the Government. I think an apology from the Government is important".)

CHAIR: Thank you, Ross, we're very interested to watch that. I'm going to hand you over now to our Commissioner Paul Gibson who's going to speak to you.

COMMISSIONER GIBSON: Thanks, Ross, you're a real survivor to be here today after all those years in Kimberley, so many places. We really appreciate that you've shared your story with us and it's going to make a difference for people in the future, I think. So thank you for the gift you've given to us, it's been great to listen to you, thanks.

CHAIR: And thank you also to the supporters who have been there with Ross helping him, I believe Allison Campbell is there and a PASAT [Personal Advocacy and Safeguarding Adults Trust] navigator. So thank you to those who have supported in giving his evidence, much appreciated, thank you.

So I think that evidence now ended, we're going to take a very short break while we prepare for the next witness, is that right?

MS THOMAS: That's correct.

CHAIR: Goodbye, Ross.

A. Goodbye.

CHAIR: We're just going to take a few moments just while the evidence for the next witness -- the setting for the next witness is prepared and we'll come back shortly, thank you.

Adjournment from 9.52 am to 9.58 am

CHAIR: Yes, Ms Basire.

MS BASIRE: Thank you, Madam Chair. Our next witness is Olive Webb, but before we start Dr Webb's evidence there is a very short clip to be played on Sunnyside Hospital if that could be played now.

CHAIR: Thank you. Welcome, Dr Webb, thank you for coming.

[Video played]

CHAIR: Before you start your evidence, do you mind taking the affirmation?

A. Absolutely.

DR OLIVE JEAN WEBB (Affirmed)

QUESTIONING BY MS BASIRE: Thank you, Madam Chair.

Please state your full name.

A. Olive Jean Webb.

Q. Dr Webb, you're a clinical psychologist?

A. I am.

Q. What area do you specialise in?

A. Intellectual disability and/or autism.

Q. Thank you. Now I just want to briefly run through your career history, so everybody understands the areas that you've worked in. We've just seen a clip of Sunnyside Hospital. You started there in 1970 and worked there for 24 years?

A. That's right.

Q. In 1973 you also began supervision of psychologists at Templeton Hospital, although you never worked there yourself?

A. That's right.

Q. You had a small private practice which you later developed into a larger practice and you worked for the IHC in the community as a contractor after you left Sunnyside Hospital?

A. I was in the employ of IHC for a short time, but then contracted, yes.

Q. Thank you. You also successfully stood for the Canterbury District Health Board and sat as a board member for 13 years?

A. That's true.

Q. And at 75 you're still working?

A. I am.

Q. Because you're passionate about this area, aren't you?

A. Yes, I am.

Q. I understand that your passion for working with people with learning disabilities and autism began as a child because you lived close to Tokanui Hospital?

A. That's right.

Q. And your mother had recognised that there were many people in Tokanui who had no contact with their families and so she started an annual garden party?

A. That's right.

Q. Can you describe for us this annual garden party?

A. Our home was surrounded by a massive lawn and on the appointed day two or three bus loads of people would arrive and out of them would spill this number of people with

obvious disabilities, with terrible stigmata, and they spent the next three or four hours doing things that people do at garden parties, eating and playing games and stuff like that, and then they piled on the buses and went home again for another year.

Q. What impact did that have on you?

A. Quite profound, I think. My mother was a woman of strong spirit and strong convictions and she simply believed that people who were different and with different abilities should be treated like anyone else.

Q. And is that a philosophy that you've taken with you throughout your work?

A. Yes.

Q. I understand as a teenager yourself you and your friends set up a youth group for some of the teenagers at Tokanui Hospital?

A. That's right.

Q. And can you briefly describe that for us?

A. We, of course, required transport, so our various parents were suckered in as well and every second Friday night we arrived at Tokanui Hospital and we played the sorts of games that at that stage was going on in other youth groups, you know, church youth groups and those sorts of things and we had a great time for a couple of hours, had supper and then went home again. And that probably went on for three years or something like that.

Q. Thank you. So then you went and trained as a psychologist, and you've been interviewed by the Commission and given a written statement ahead of today's hearing, and that statement was effectively based on the questions that we asked you?

A. That's right.

Q. However, there is much that you could say about the area of people with learning disabilities and autism and, in fact, there's so much that you do want to say about your life's work that you're writing a book on the subject, aren't you?

A. Well, yes.

Q. So we appreciate there's much that you could say in this area and that we only have an hour and a half today, but today what I'm going to focus on is what you observed at Sunnyside Hospital in the 1970s and 1980s, what you knew about Templeton Hospital at the time, I'm going to ask you about the subject of over-medicalisation of people with learning disabilities and autism, which is a subject that we've already heard about from other witnesses, and then I'm going to be asking you some questions about why you think abuse and neglect happen in institutions, and what your concerns are currently for people in community care.

So, first of all, I want to take you to Sunnyside. We've just seen the footage of Sunnyside Hospital, and when you began in 1970, was it those big imposing gothic buildings that we saw on the video?

A. Yes, we were starting to phase those down. The fences were gone when I started, but the building, and it was always referred to as "the grey building", stood there and typically housed long-term patients, usually long-term psychiatric patients.

Q. Right. I understand in 1970 there were about 1300 patients at Sunnyside Hospital?

A. That would be right, yes.

Q. Can you describe how Sunnyside was structured when you first began in 1970?

A. Yes, it was divided into a number of, if you like, functional areas, so there was an acute area to which new admissions of people who were acutely psychiatrically unwell were admitted and treated and discharged.

Then there were -- there was the forensic service for people who were either being assessed or had been determined to be criminally insane, and with them was a number of people who were just simply considered dangerous and so were kept there.

Then there were some wards of long-term psychiatric people, people with long-term disorders like schizophrenia and those sorts of things.

And then there was sort of a rag bag, if you like, of three areas that were mainly comprised of people with intellectual disabilities, many of them had been admitted decades before and there was no plan to progress them back into the community, they were considered to be long-term residents and it became known as "the mentally handicapped area" in the English language of the day, and that was the group that I became associated with.

Q. And I understand that they were colloquially known as the "back" wards?

A. Yeah, and that meant that it was difficult to get psychiatrists to go there even, and we tended to have a lower ratio of fully-trained or recently-trained people working in those areas.

Q. So the people in those wards were effectively forgotten?

A. Yes, yes. They were almost a self-sufficient institution within an institution.

Q. When you first began working in Sunnyside, what was your role as an assistant psychologist?

A. Oh, at that point my main role was working in the acute and semi-acute areas. I worked in an adolescent unit, I worked in the acute areas, and did what I needed to do as part of my professional training.

Q. How was it that you ended up working in the back wards?

A. Well, I'd had my home grounding of course, and I had known, through the family, people who had intellectual learning disabilities, and I had an interest in the relationship between the environments in which people lived and how they behaved, and just immediately next to the psychology department was a very long-term back ward and I got permission to go and spend time there, which of itself generated a lot of anxiety because most psychologists didn't go there.

Q. So it was your own motivation that enabled you to start working in these areas and effectively in 1974 you were appointed as a psychologist for the, what was called the Mentally Handicapped Area?

A. I was -- yes, I was a registered psychologist at that time and I was made clinician in charge, a noble-sounding term that put me as the manager of that service area.

Q. And this wouldn't have happened unless you'd shown an interest in the area?

A. No.

Q. I want to take you to your description of North House which was one of those wards. I understand there were about 70 men in that ward, and those men were predominantly Pākehā?

A. Mmm-hmm.

Q. And aged between about 50 and 70?

A. Yes, I'd say, yes.

Q. We've just seen a shot of the dormitory, can you describe what North House looked like in terms of the sleeping arrangements?

A. North House was quite different to what you saw there. In North House, there were about 70 men living there, there were two or three dormitories, and I remember well my first tour of the ward, I had to move sideways to get in between the beds, they were sufficiently close together, and at the end of each dormitory there was a lobby that had the clothes store in it. People didn't have their own clothes and so they fished around and found something that was usually too big or too small.

The first day that I spent there I was there early in the morning and these men were -- got up from their beds, shuffled into that lobby, stripped naked, they were then marched, or sort of herded really, through the main villa and through the end of the day room, into this large bathroom that had multiple shower heads, they were showered en masse by nursing staff who were wearing rubbers and gumboots. They were then taken out and dried and then herded back to the lobby where the clothes were.

Q. So they were herded back naked after the shower?
A. Herded back naked, yes, yeah. And that was their morning routine.
Q. What did it remind you of?
A. Concentration camps came to mind.
Q. What was their daily routine after they were given breakfast?
A. They were ushered through into what was called a day room, which was a room probably about half the size of this room, and there they sat.
Q. And did nothing?
A. Did nothing.
Q. You've described that in your statement as a complete removal of thinking, creativity, dignity and independence?
A. Yes.
Q. If somebody was to visit these men, what was the procedure for visiting?
A. The main day room, as I say, about half the size of this, had another room on the end of it and on the end of that was a door bell and there was a funny tiny little porch there and in order for people to visit, they had to press the door bell, wait while a staff person went there, "Who do you want to see?" "I'll go and see if you can see him," and went all the way back and there was often about 45 to an hour wait that the visitor had to withstand in order to be able to visit their person. What it meant is that in times of bad weather, people didn't visit, it was too hard, it was a huge barrier to social contact.
Q. Right. Who had the power in these wards?
A. Nursing staff.
Q. What would happen if a nurse thought that a patient had done something wrong?
A. This is not just North House, this became general and was still general by the time I left. People would be put into their pyjamas, taken out of their clothes, put into their pyjamas, and made to sit in a chair outside the nursing -- Nurses' Office. From there they were told to go for meals, they were -- they had to ask if they wanted to go to the toilet, and they were confined to that place until somebody said differently.
Q. And so that was a way of stigmatising them as having behaved badly?
A. Well, it was a bit multi-purpose, because certainly that was true, but it was also true that if they were unwell then the same things happened to them, but then it was rationalised as the need to be closely observed. But their experience was the same whatever the cause, so it was embarrassing, often caused sort of ridiculing comments, "Oh, so what have you been up to?" sort of statements as people walked past, yes.

Q. What sort of behaviours would trigger a nurse thinking that somebody had behaved badly?

A. Oh, being non-compliant, getting cross with somebody, acting out in those sorts of ways, yes. It didn't take much.

Q. Was there any attempt to understand why a person was behaving that way?

A. I think we were a bit more solutions driven than that at the time, that if somebody behaved that way then that's what happened rather than "let's find out what is troubling this person", yes.

Q. You've said in your statement that restraint and seclusion were often used. What sort of restraints did you see?

A. Restraint was common, which could have occurred if somebody was being non-compliant and challenging orders, as it were, or if somebody was acutely unwell and therefore behaviourally out of control, it would be common for them to be restrained by two or more, and sometimes a lot more people, and then secluded.

Q. And what did the seclusion facility look like?

A. The seclusion room was a bare room with a shutter, so a reinforcing over a window, a mattress on the floor, and a potty.

Q. How long would people be kept in these rooms for?

A. It varied. There was a belief that seclusion was somehow good for people who were disturbed because it reduced their level of stimulation, and so if people were unwell or still angry and fighting the system, this would of itself extend the period of seclusion. So there was not the control then, 1970s, there was not the control on the hours and days of seclusion that there is now.

Q. Now you also mentioned to me that control was achieved effectively through intimidation. Did the hospital employ members of staff who were physically imposing?

A. Absolutely. And it was common practice that if somebody was felt to require seclusion, to ring up neighbouring wards so that you'd have half a dozen or eight burly men appear on the scene and a person would be intimidated into seclusion in that way.

Q. Now I want to talk to you about the power imbalances and patient neglect. You've told us in your statement that adult patients always had to knock at the door of the staff room?

A. That's right.

Q. So the staff were at the top of the hierarchy?

A. Yes.

Q. Patients were not meant to interrupt?

A. That's right.

Q. Nurses would say, "Don't talk to me now --

A. That's right.

Q. -- I'm busy." And it was because the nursing staff ran the show?

A. That's right.

Q. You've said in your statement, you've given us a couple of examples of neglect, specific examples. Of course, you've told us already that these men had no stimulation, they just stayed in the day rooms. You've talked about one guy who stood against the wall?

A. Yes.

Q. What was the physical result for him of always standing up beside a wall?

A. It sounds really bizarre. We discovered when we wanted to take people swimming that his standing by the wall had meant that his scrotum descended just about to his knees, and so we had to get special clothing for him so that we could take him swimming and get him moving, yes.

Q. And I'll move on to, in a bit, the rehabilitation programmes that you implemented, but I assume when you first started in North House, nobody was taking these men swimming?

A. No, no.

Q. Another example you've told us about is a man in a long bed-chair and he was always in a bed-chair, never up and standing?

A. That's right.

Q. Can you tell us how it was you and a physio discovered why he was in that chair?

A. It was quite simple, a physio who I -- who worked with me in the area said, "Why is this man in a bed-chair?" And we went through his notes and discovered that about 10 years before he had broken a hip and there was no reason for why he should be in that bed-chair. And -- so she went to work and it took quite a long time, but we actually got him up and walking again. If you're horizontal for many years, it has all sorts of implications for your vestibular system, but she got over that and he became able to walk again.

Q. So this man for 10 years had been in a bed-chair because nobody had bothered to give him rehabilitation to get him walking again?

A. That's right.

Q. In your statement you've told us that you wanted to be clear that you never saw many incidents of outright abuse, but you felt it was the system that was abusive?

A. Yes, I mean, like everyone else, I'd been reading some of the snippets of reports that have been made here, and hand on heart I did not -- have not seen an individual staff person being cruel. But the systems in which everybody lived and worked were terribly cruel,

because you had one group of people who had the power of life and death and daily activity, and every single piece of power that you could wish to have, completely dominating another group who had absolutely no power at all. They didn't decide what they ate, what they wore, where they went, or anything, they were simply -- they were required to be obedient.

Q. Why do you think that was deemed acceptable at the time?

A. I think it's about the value systems of the day. You know, "these people" were -- this was considered to be an appropriate place for "these people" and "these sorts of people". They had no value and it was considered to be our social responsibility to keep people warm and well fed, end of story.

Q. So effectively because society placed no value on these people, it was considered that they were being kind to just feed them, water them and have a roof over their head?

A. Mmm, yes.

Q. How did you feel about what you were seeing in these wards?

A. Well, it was just so wrong. Because so often we come across people who lived -- I came across people living in these situations and they were there by some accident of birth, exactly the same sort of person with similar abilities would be born to a different family, with different opportunities and different things would happen. And there's not a rational reason for that.

I've lost my thread now, which is probably good.

Q. That's all right. You said to me earlier that the Government effectively sanctioned this behaviour by legislation because back in the 1970s you could be committed into an institution such as Sunnyside Hospital if you were deemed incapable of looking after yourself?

A. Yes, I did say that, but we're actually going back longer than that, because I think '72 or something was the first new Mental Health Act, somewhere around that time, I'm not quite sure. Prior to that, you could be formally committed to care if you were unable to live independently and make decisions about your life, and that was the legislation that enabled people to be committed or formally admitted to the psychopaedic hospitals, and in early years to Sunnyside Hospital, people with intellectual -- learning disabilities.

Q. I understand you were inspired by a number of people internationally, including William Gold?

A. Yes.

Q. Can you just briefly explain what his philosophy was?

A. It was very simple. He taught people with severe learning disabilities complex tasks without ever telling them "No, you're wrong." He just simply said to them, "Try another way." And people tried another way and for many years he had people assembling 22-task bicycle brake assembly units commercially by simply following a jig board and performing the task and getting paid properly for it.

Q. And because his view was if you try another way, just let's see what happens?

A. Mmm.

Q. So you decided, when you were made head clinician, as you say, a very important sounding title, head clinician of the Mentally Handicapped Area, as it was termed on that day, that you would try another way. Did you have support from your bosses at the time?

A. From my psychology bosses, yes. But I was regarded sceptically by staff within the Mentally Handicapped Area, and I taught somebody quite quickly, in a couple of afternoons, to do an equally complex task, and I was told, "Well, of course they can do that, he can do a lot more than he does now." And this knowledge didn't seem to spur anybody on to put more into this guy's life, you know.

Q. Right. So what you're saying is that you taught one patient something and the staff go, "Oh yeah, we know he's capable of this, he used to be capable of a lot more", but they didn't see that as neglect, that they'd allowed it to become that he wasn't doing anything?

A. No, no.

Q. I understand there was quite opposition to you introducing new measures, and there were in fact complaints to doctors and nurses, governing bodies?

A. It wasn't so much complaints about me, but because my position was the first time that a non-medic had been made a service manager and so the nurses went off to the nurses union to seek reassurance that this was ethically okay and, similarly, the medical officer who worked in the Mentally Handicapped Area went off to the Medical Council to make sure that it was ethically okay for him to be directed by a non-medic.

Q. It's somewhat ironic given what was happening to these people?

A. Mmm.

Q. We're not going to be able to have time to talk about all of the things that you did in terms of rehabilitation, but I just want to take you to some of the first examples that you gave us. I understand that you chose a small group of people because you knew that you had to show success to get support?

A. That's right.

Q. Can you describe what you did?

A. We made a decision, first, that everybody has a sort of a vaguely protestant ethic type of responsibility to make a contribution to their own life. So we wanted to put half a dozen men in North House, who we knew had the ability to do this, and we gave them a tiny task, they were actually putting stickers on the backs of bibs that were subsequently used in the geriatric area, and they worked for about 45 minutes a day. They were paid with tokens, which they then went and exchanged for goodies they couldn't get otherwise at the so-called ward shop, which was run by the nurses. Two things happened.

The nurses thought it was great because it turned them into a sort of Santa Claus type of role and got them out of the disciplinary type and management type role. But within about two weeks, there were about 20 other men from North House who had come in and had started to notice what was happening, and my OT at the time threw out some tables and provided them with exactly the same work. And so within about three weeks we had this group of half a dozen working and being paid for it, and another group of about 20 who were there because they were interested.

Q. And I understand that the other villas caught on to what was happening in North House?

A. Yes. One of the other villas had been quite stroppy and resisting interference by somebody like a psychologist and when this started happening they became very angry that they were being left out and omitted. And so we then had an event in that North House was closed, that population plus some others went to a new villa, the other villa, there was some shuffling of people there, so we started this as: This is what we do in these new villas. And from thereon out we had work programmes in the morning and activity programmes in the afternoon.

Q. And so what you're saying is that the opportunity afforded by a change of location meant it was easier to change practices?

A. Yes.

Q. Of the staff?

A. Yes.

Q. I understand that in the 1980s you were asked to be involved with ward 1?

A. Yes.

Q. Ward 1 was different because it was seen as the sick ward or the dying ward. And you've mentioned that it was quite normal in a large institution that people get sick and require physical nursing and so that's where these patients would go?

A. Pretty much so. If they were long-term patients at -- in the wider hospital, they would just as likely as not end up in ward 1. End up.

Q. So when you were working in ward 1, what you saw was people appearing to be on the brink of death being treated with vast amounts of antibiotics, but again, there was no activity for them?

A. That's right.

Q. And you recall one woman whose hands were locked due to just sitting with her arms folded for decades?

A. Yeah, she sat like this, and every day her hands were -- fingers were prised open and were painted with Mercurochrome to stop the fungus from growing, and then she would sit like that again.

Q. So for her and other patients, what change did you implement?

A. Well, I'm a pianist, and so the big thing that I did, supported by the OT and the physio, was I went in there for 45 minutes every single day and we played "Roll Out the Barrel" and "The Saints" and all of the old songs and got people moving. And, you know, the responsiveness, we're talking within two or three weeks, people would -- or less, people would start and you'd see them, their eyes open and you'd see a foot tapping and it was sort of inchworm stuff. And you could see the lights coming on, it was just fantastic.

Q. You mentioned you could see the lights coming on. From your experience, what is the importance of physical movement to mental health?

A. It's fundamental, absolutely fundamental. I mean, just look at your child development patterns, you know, your physical movement, sensory mode of development, that becomes the basis for cognitive development, and -- yeah.

Q. So by getting these people moving, their physical health improved, their cognition improved?

A. Yes, and an interesting phenomenon in ward 1 was that, and I don't have -- didn't collect the data, it seemed a bit -- I didn't collect the data formally, but once people were moving and moving consistently, we tended not to have the chronic demise at end of life, people lived better and died quicker, if that makes sense, that was our perception of things.

Q. So effectively people didn't die. Once they were given intervention, that got them moving?

A. They didn't die with the long chronic disablement and deterioration.

Q. Right. You talked in your statement about a patient who'd been found living in a chook house?

A. Yes, yes.

Q. Can you tell us about her?

A. She was a great lady, and she -- she had cerebral palsy and so she was quite hunched up and constantly looking down and she spoke very, very little. And we got her a job and she worked for a wine and spirits agent and she sat in the front seat and she held a clipboard and after she'd been doing that for two or three months she started to sit up straighter and she started talking to the driver and noticing what was going on. It was fantastic.

Q. And so that's a concrete example of changing her environment --

A. Yes.

Q. -- completely changed her?

A. Absolutely.

Q. By the late 1980s, you've noted that there was a group of senior nurses who led a movement for patients to have their own clothing?

A. That's right.

Q. So I understand internationally there was a lot of evidence supporting deinstitutionalisation?

A. That's right.

Q. And treating people more as individuals?

A. That's right.

Q. And obviously the nurses had picked up on this?

A. I think these particular nurses were quite ahead of their time at that time, and were quite strong on the business of -- I mean, there used to be meetings, national meetings and people decided on the pattern of dresses that would be made next year for the long-term residents, and they had to be careful because if they put an extra dart in then the implications for cost for 2,000 dresses are enormous, and, you know, they said this is ridiculous.

Q. So throughout the 70s and 80s when you worked at Sunnyside, all the people that you were working with, were all dressed the same?

A. Through the 70s. I think around about the 80s it will have changed.

Q. I just want to briefly take you to your experience of Māori patients in care. You said the people that you worked with predominantly in Sunnyside were Pākehā?

A. That's right.

Q. But in your statement you do recall -- well, in fact, I'll go back. What your observation was, was in the learning disability area of Sunnyside?

A. Yes.

Q. What was called the Mentally Handicapped Area. But, of course, there were other areas of Sunnyside with mental health acute services?

A. Yes.
Q. And in those services there were many more Māori patients, weren't there?
A. That's right.
Q. But just focusing on the area that you were working in, you recall a time, and was this in the 1980s when biculturalism was being introduced into Government departments?
A. Yes.
Q. And Ngāi Tahu had a hui?
A. Yes, the then superintendent Les Ding collaborated with Ngāi Tahu and there was this huge concert hall at Sunnyside, so this became a wharenui for the purposes of this hui, yeah.
Q. And I understand, because there was the one Māori patient who was Ngāi Tahu and they wanted him there, and he slept on an elevated mattress at the top of the hall because of his status?
A. That's right.
Q. And the hui was for staff. What did you observe of the staff being put in a position where they were put lower than somebody that they considered mentally retarded?
A. Well, I thought at the time that it was enormously funny because the patient in question was this amazingly dignified gentle man who conducted himself absolutely superbly wherever he was and to see him, a patient, up front while people were learning to overcome their personal barriers to biculturalism and all the rest of it, was fantastic. But quite dissonance-generating for a number of people.
Q. I want to turn now to Templeton Hospital. You told us that you never worked directly at Templeton Hospital, you supervised other psychologists there?
A. That's right.
Q. But you frequently spent time at the Riding For Disabled, which we heard about yesterday from Tony Ryder?
A. That's right.
Q. Effie Deans was running that unit. And you visited the wards and facilities and you also later visited when you were working for IHC. What was your memory of the wards at Templeton?
A. In my role as supervising psychologist I virtually didn't get into the wards and I think it's possibly fair to say there that the psychologists operated on the periphery of the operation of the whole facility, if you like, so that people tended to go and see them rather than them go into the villas to see people. And so, you know, it's my sense that psychologists had a somewhat -- they were in a bit of rarefied air really, and we knew -- we heard complaints

from people like Tony about the things that particularly some of the ward charges did, but it was not the business of psychologists there. And so there, again, I think occurred this sort of passive ignoring of it.

Q. In your experience, how hard is it to implement change in these large organisations?

A. It's huge. There is a huge what I can only call a knocking brigade that, you know, like with my person, "Oh, we knew he could do that", but we haven't bothered to do it, and so there is this sort of scepticism, or there was this sort of scepticism and, "Oh, well, we'll see how it goes" and, "Oh, I don't know." And quite often a tacit "down tools" and just lack of co-operation.

Q. So you could have a brilliant idea, ask for it to be implemented and if the staff working in the areas weren't on board, it just wouldn't happen?

A. No, and certainly in my own experience when I wanted to introduce anything that was even slightly new, that what we -- what I had to do was work very hard to get key staff over the line before we even tried.

Q. You've mentioned in your statement one example of how Templeton was run and it came to your attention, I understand, because there was a request for a behaviour modification with one patient and this is to do with the curtains and toilet paper?

A. Oh, yes, yes.

Q. Can you describe for us that situation?

A. Towards the end of my time at Sunnyside I became increasingly involved with IHC. And IHC had a behaviour support specialist team and one of these -- this team was asked for support because there was this new resident in a long-term ward at Templeton who kept wiping her bottom on the curtains and so this behaviour specialist went to the ward, introduced toilet paper for the first time, and the behaviour disappeared.

Q. It seems incomprehensible that the patients weren't given toilet paper.

A. And it's not unusual.

Q. I understand that the bathrooms at Templeton would have six to eight toilet pans without partitions between?

A. Yes, I remember one day in particular where I was taking a person who was a very senior community person, I was sort of hosting her really, and we went, we were in Totara Villa and the bathroom doors were flung open in order to show this dignitary the bathrooms and there were six, six, and six toilets going directly out from the wall, and there were 18 guys all sitting on these toilets and then one leapt up to change the radio station, which was

going, and sat down again, and we were told with an element almost of embarrassment, "Oh, we call this the milking session", and we went on.

Q. So that's indicative of the views that the staff had towards the patients?

A. Well, I think even that makes it too concrete, this was just what was done. It was the way things happened. And I suspect that a whole lot of people never even asked the question if this is the right or the wrong thing to do; this is just the way it was.

COMMISSIONER STEENSON: Can I just ask a question, Dr Webb, about that?

A. Yes.

Q. So you said that was not unusual and you're meaning the attitude and general treatment?

A. Yes. Yes, we're talking -- I mean, it jars now, and I think we can be pleased with the progress that we have made. But this was simply the order of things, that the person with disabilities was at the bottom of the heap and didn't have any sense of redress or dignity or privacy or embarrassment, those things didn't apply. It was just assembly-line type care, mmm.

Q. Not unusual?

A. Not unusual at all.

Q. Thank you.

QUESTIONING BY MS BASIRE CONTINUED: We're not going to spend any time at all, unfortunately, on the deinstitutionalisation process that you were involved with, it's a whole topic by itself, but why were you so passionate about deinstitutionalisation?

A. Well, it was just -- you see, the things -- one of the things that we haven't talked about, apart from this terrible order of things that institutions encompassed, institutions are also secret and, you know, I grew up, as I've said, with people who had disabilities who were not in institution, but also, you know, 40, 50 years ago we all understood that there was a place for people like this. And what went on in those places, who knows. You know, and the sexual abuse and all of the other things, which I know you've had described to you, fit in with this sort of animalistic sort of conceptualisation of the person with disabilities, that you have to contain them, you have to contain their sexual urges, you have to keep them clean, they have to -- you know, but how you do that is quite different.

Q. And so you were actually seconded to the Department of Health for 50% of your time to help with the closure of the psychopaedic hospitals and psychiatric hospitals?

A. Yes. That's right.

Q. And we all know that that process happened and now many people with learning disabilities live in the community?

A. That's right.

Q. And so the next focus of your evidence, I want to talk about what it's like for these people today from your experience. One of the topics I want to talk to you is about over-medication. We've heard consistently from survivors that they were placed in day rooms in these institutions and given pills with their breakfast, lunch, and dinner to keep them sedated and calm.

I understand that when you were working for the IHC in 1999, which is the period where people had just moved into the community, you did some research to see what level of medication these people were currently being prescribed. What did you find?

A. Yeah, the concern when people were in the institutions was that they were over-medicated in order to control any particularly aggressive behaviour. But there was the added benefit with the use of a drug called Mellaril, or Thioridazine, that drug caused erecti le dysfunction in men, and so the use of that fitted with the eugenics type of movement that these people should be prevented from breeding.

So when we got into the community situations, there were a number of people throughout the Western world who thought this is great, we're in the community, surely the medication use will have dropped by now. And so in parallel a number of us researched just that question and found that the use of medications in community settings at that time was exactly what it had been in the institutional settings.

Q. And I understand, you have said in the community settings you might have one staff member and six people in a house, and if one resident becomes aggressive, even today medication is the first port of call.

A. That's probably a little bit of an oversimplification, but yes. Some of the medications being used now are more targeted towards treating anxiety states, but nevertheless it's a pharmaceutical option to actually sitting down with somebody and finding out what i t is that troubles them.

Q. So effectively carers are ignoring the message that their people are trying to communicate through behaviour, not necessarily overtly, but haven't found a way of understanding what that behaviour means?

A. I don't want to oversimplify it, I don't want to blame the caregiver for this. If you are supporting half a dozen people and you're also responsible for cooking their meal and for getting them through their evening ablutions, whatever they may be, and you have somebody who becomes cross or wound up, then that caregiver doesn't have a whole lot of options, and the -- I think the problem arises where the emergency solution of using

medication to get somebody over a hump becomes a long-term solution and so the issue that's generating this is never addressed.

Q. So something that could be very acceptable to manage an acute situation becomes a long-term medication?

A. Yes.

Q. And just briefly --

A. I mean, I think -- can I just add that, to me, the issue comes back to funding and there being just one person responsible for six people and responsible for doing all of those things.

Q. Right.

A. So we are employing people to be jack of all trades and master of none and some of them are absolutely brilliant, but it's a big ask.

Q. And I had skipped over it, but just briefly, your observation in the institutions was that medication at times was used for punishment?

A. Absolutely, absolutely. And in my statement I cited the example of a medical officer -- the same one who had challenged my position -- went out and he'd made somebody angry, it wasn't hard to do, and they'd bent his windscreen wiper and he charged back into the hospital in a rage and increased the person's medication.

Q. And nobody questioned it?

A. No.

Q. I just want to touch on current-day issues. You've said that when you were working for IHC you introduced annual health checks and what the data showed is 73% of people with learning disabilities and autism who were in care, or of disabled people in care with IHC, required significant health interventions, cataract operations, cancer screens, dental work, pain management and more, that -- and they weren't receiving that basic health. You've also told me that in terms of disabled people's mental health that it only gets to when the level of their behaviour is so disturbed they're considered in need of forensic containment, restraint and sedation, that anybody looks after their mental health needs?

A. First things first. In terms of the health -- their health needs --

Q. Dr Webb, can you just pull the microphone a bit closer?

A. Sorry. In terms of their general health needs, we have a particular primary healthcare system that requires us to go to the doctor and complain about what it is that is wrong with us. And that act of complaining requires insight, body awareness, and cognitive and linguistic capacity to do that. And whilst there are a number of medical situations where

people are trained to treat people who are not speaking at all, in primary health it's quite a leap and there's quite a lot of research that has supported that view. So that's one.

So it means that we have to be very deliberate in presenting our person to primary healthcare in a way that whatever ailments they might have will become obvious.

Q. So, effectively, you're saying those who work with learning disabilities, people with learning disabilities need to be so proactive to achieve primary --

A. Yes.

Q. -- healthcare. And that includes recognition of ordinary needs such as anxiety, grief, relationship adjustment, environmental stresses, these are all things that the person may not be able to describe and so therefore no interventions are put in place?

A. Yes, that's correct. Two things: The physical disorders are one thing. With the emotionally charged challenges, what -- the quick use of medication to suppress behavioural symptoms means that we have not only over-medication, but we have under-diagnosis. And so it's not until -- it's frequently not until the emotional state is so intensified that it can't be ignored, that we can then start to attract specialist attention. By then quite often the behaviour has become sufficiently disturbed that the person might commit a crime, might have a reputation as being difficult, and so the usual early intervention for those emotional disorders is missed.

I might add that in addition to -- a third compounding factor is that typically medics in this country get one to two hours at most teaching about intellectual disability and those issues that stem from that. So it's a difficult – recycling thing.

Q. Would you go so far as to say there's a chronic under-training in this area?

A. Absolutely. Absolutely.

Q. We're going to talk about funding in a minute, because that is a real concern that you have. But I just want to talk to you about why it is that you think in the institutions and perhaps also occurring today in community care settings, that there is abuse and neglect.

Now, you've said to me earlier, and I just want you to quickly touch on this, without identifying the care home, there is a care home that you can see parallels from the institutions happening today?

A. Absolutely. There are some -- I mean, it's important to understand that if you -- if I live in a home with 10 other people and therefore require two or three staff at any given time, then it means that that two or three staff times five, which is the number to get 24 -hour staff, means that every week I have 25 people going through my life, add that to the 10 people who live there and I've got 35 people living in this unbalanced care home, and where that

occurs there is a retreat, if you like, or a perpetuation of institutional practices where there are staff offices, there are staff toilets, I'm thinking about a place in particular, where the kitchen is locked, people have to ask permission to have a cup of coffee, to have a nibble in between meals and all of that sort of thing, and it's terribly secret, and that to me makes it worse.

Q. So, effectively, what you're saying is the deinstitutionalisation process brought people out to the community but we still have to be really careful to ensure that this is not being replicated in community houses where the secrecy continues?

A. Well, it's not only that, but it's almost like where you have a group of people with disabilities living together and relatively powerless, being supported or supervised or managed by people who have all the power, then what you've got is a -- it's like putting a lens over the less visible but still apparent value disparities that exist today, that they become, again in much more acute relief, people like them who need us to look after them.

Q. Right. You've talked in your statement about the concept of "them". Can you briefly explain your thoughts around the concepts of "them and us"?

A. Well, to me it's about power. It's about power, and if I can borrow a story from Tony, who -- I'm Tony's welfare guardian and we were driving past some pre-fab houses one day and he said to me, he said, "You know, Olive," he said, "I could put one of those houses up in the bush and you'd be able to go outside at night and see the stars and there'd be no staff or anyone." And you see, that's parity.

Q. And that's what he wants?

A. Mmm.

Q. Individuality?

A. Mmm.

Q. So if you conceptualise treating people with disabilities as a group and then well-meaning people do things for them, fund them?

A. Yeah.

Q. Provide for them?

A. Yes.

Q. But we don't get to the core of the problem?

A. No, because we -- I mean, the current needs assessment system that dominates our funding essentially is a way of finding out what we think this person needs, which can be quite different from what they would actually like.

Q. Yes. And you've mentioned in your statement, staffing standards and you said in your statement, and I'll read it out: "When you go to a posh retail store the measure of the service is the degree to which the customer is satisfied and the degree to which the shop is concerned about the customer being satisfied, but we don't do that with disability services."

In fact, your view is the customer becomes the funder. Can you explain that?

A. Because I think -- yes, and it may be a more cynical view than some have, but I -- you know, the service provider, the person who is actively spending the money, if it's a service provision, they -- the ease with which they can get and provide what they believe they should provide determines the funding, not whether somebody has got the latest wheelchair or the best prosthetic or the best whatever, or the ability to socialise with and when they wish.

Q. So, effectively, the funder is more concerned with efficiencies of money spent?

A. Mmm.

Q. And that doesn't allow, in your opinion, the room for the individuality that you think needs to occur?

A. Well, I think that as individuals who spend their own money, we are remarkably inefficient and we waste an enormous amount on trivia and stuff like that, which is the bric-a-brac, if you like, of living.

Q. But disabled people are prevented from that?

A. There's no funding for bric-a-brac, no.

Q. And in fact no room for bric-a-brac?

A. No.

Q. Why is that?

A. Again, you know Tony, Tony has one room, he's 60 years old and he has one room and we're contemplating shifting house right now after 20 years and I tell you it's going to be a mission, but not for Tony.

Q. You've set out in your statement an example of a service that you think is doing really well and that's called Living Options in Central Otago?

A. Yes.

Q. Can you describe for us the young girl with Down Syndrome that you were asked to see and what it was that that service did at putting her needs first?

A. The person I was asked to see had Down Syndrome, she was acutely traumatised, she had been sexually abused by our systems as well as by individuals and I thought when I first met her she was so disturbed I thought she had acute autism, and I took her -- it's a long

story, doesn't matter -- to this Living Options in Alexandra, and the woman in charge of that service who is herself a psychopaedic nurse, spent some time with this young lady, when she was 10 or something, and then went and spoke to her staff and said, "Now, I've been speaking to this lass and she tells me she wants to be a princess, so if you're not sure what to do, just imagine her as a princess and that's what you will do." And the staff, you know, and I thought, you know, psychologists, I could have had clip boards and all sorts of things going in all sorts of direction, but this woman and that service encapsulates the humanity of people and can understand how different people in the same situation with different attributes will respond to that situation differently and she has the ability to build on those experiences and the service is fantastic.

And I have it informally that it's actually been considered that by some of the evaluation services.

Q. Right. So everybody when they weren't sure how to treat her, treated her like a princess?

A. That's right.

Q. And what was the outcomes for her?

A. Progress is never made in a straight line, but the culmination of this lass's progress, to me, and it just exemplified what happens when you respect people, she was attending the high school in Alexandra and she went to the -- and her boyfriend – went to the end-of-year ball, they're both Māori, and so they were wearing korowai and the red carpet was laid out, they got a round of applause, her boyfriend also has Down Syndrome, they got a round of applause as they went in to the school ball and through the night the head girl spoke to the live band leader and asked them to play her song and she took the mic and she sang Dancing Queen.

And I reckon that's mainstreaming, I reckon that's integration, I reckon that's respect, and how she got from there to being locked up for weeks in a CYFS [Child Youth and Family Services] home as a three-year-old is quite remarkable. But this is this lass's journey, you know, and yeah. It was great.

Q. You've also mentioned that the change to community care settings has been more easier for people who are seen as compliant?

A. Yes.

Q. And you've used Tony as an example. What do you notice with people in the current community care settings who are more individual and less compliant? Is their journey as easy?

A. No, no, I mean, Tony is considered to be very challenging, and he asserts himself and he asserts himself very positively at times, and he manages to -- he has rules about who's allowed in his room and who's not allowed in his room and that's considered to be quite difficult to cope with at times.

Q. So he's considered as having challenging behaviours just because he wants to have control who's in his bedroom?

A. Yeah.

Q. And this is a 59-year-old man?

A. Mmm.

Q. What, just briefly, you've talked about how hard it is to implement change. If you could wave a magic wand, what would you like to see happen in the future for people with learning disabilities and autism?

A. It's this mixture of listening to people and watching people, and, you know, the most challenging person in the world will have times and places and things in which they're never challenging because they're happy, because they want to be what they --where they are and they want to be doing what they're doing at that time. And it's about getting away from the one size fits all. You know, it's about, you know, our community people, particularly with intellectual disabilities, typically they're not hugged, they're not touched, they don't have an intimate life, and it's sort of, I don't know, it's just about, we have to devolve -- I know that we need our bureaucratic systems for managing and handling funding and all of those sorts of things, but they should come after the intimate assessments and the, you know, really what is it in this world that is going to make this person happy. And we've sort of -- we sort of have shied away from that, I think it's awkward.

I went to a so-called programme review meeting once and people had actually written at the top of the form that they were filling out: "We asked Johnny" or whatever he was "what he would like to do and he said he'd like to go to Disneyland, and we explained to him that that's totally unrealistic. His needs therefore are ..."

And so the form was filled out.

Q. So they ignored his wishes?

A. Mmm. And I just think there's better ways of doing things, even if he couldn't have quite got to Disneyland, he could have got somewhere like it, you know.

Q. They could have taken the core of his wish --

A. Mmm.

Q. -- and seen if that could have been accommodated in some way?

A. Mmm.

Q. Thank you, Dr Webb, I know there's so much more that you could tell us and I know the Commissioners will have some questions for you, so I'll just hand over to Madam Chair for any questions.

CHAIR: Yes, thank you. Paul, do you have some questions?

COMMISSIONER GIBSON: Thank you, Dr Webb, really appreciate your evidence and the work you've done over many years for people with learning disabilities, people with autism. Following up on some of the questions, the way you describe needs assessment, we should be throwing it out now and I think there is some intention to transition towards different models. Do you think that people that have been involved in NASC systems, Needs Assessment Service Coordination systems, can themselves or their organisations, their structures, easily transition to something new which is really focused on the person and their dreams?

A. I do actually. The NASC that I have most to deal with is LifeLinks in Christchurch and I have go-to people there that I occasionally ring up and say, "What do I have to write in order to get this to happen?" And my experience is that people will say, "Yes, this should happen and this needs to happen, now let's see what we are allowed to provide." And that's where the difficulty is, it's about this inflexibility.

I mean, I was -- I can get support for a person with autism, but what happens -- and the grand dream might have been to then take this person and increasingly integrate them into a wider social setting and that sort of thing. But what I get is somebody, a support person who comes along for those hours a day, sits with him, does stuff, and then leaves. So to actually get a meaningful interventional person at that level is quite difficult at times.

Q. So it's support people, but also what you described, I think, the situation which they're in, almost like the six-bed- or the 10--bed house seems to be redundant going forward, that model needs to be --

A. If you happen to have six people who like to live with each other and who want to do their own thing together and all the rest of it, then it might work really well. But if you're compromising individual needs for the sake of what is an efficient model then I think you have problems. I've lost my thought, no, that's fine.

Q. That's helpful. You talked about Mellaril and links to eugenics. Just thinking today, how are disabled -- people with learning disabilities as parents supported by the system both men and women, pregnant women, by the health system, by Oranga Tamariki?

A. That's a very interesting and quite loaded question. Because I have explored the foundation statements of not only the UN conventions but also of Oranga Tamariki, and what is clearly clear from what needs to be quite in-depth researching of the Oranga Tamariki website, is that there is a commitment to supporting a child's right to family life, ie to be with its mother, but the barrier to actually providing this, the ability to do this, often lies in the multi-agency collaboration that is required to achieve it.

Now, I would have to say that in my practice, my private practice, a common referral is from Oranga Tamariki who say, "I have this mother who has an intellectual disability and therefore is not capable of raising her child, and will you please write a report that says that so that we can then take a without notice order and remove this child at birth"? And in many cases, I might add, that request for the assessment has come in the seventh, eighth or ninth month of pregnancy so that at the point of birth, you know, with nine months' notice, there's been no planning and the baby is simply removed.

It flies in the face of the UN Convention. My personal view is that the thing that a mother can do is love its child and what we know about intellectual disability is that the people out there now who are surviving quite well do so without intimate love, and so if we can have a baby born which is loved by its mother and get somebody else to do all of the other stuff, that's what happens in lots of places. It's what used to happen in this country in the early ’70s and ’80s, there were intellectually disabled parents living up in Whangārei and J. B. Munro, who you all know, set them up with grandparents and a family situation so that the mother could love the baby and the other stuff got done. I feel a bit strongly about it.

Q. Thanks, really appreciate that, and I appreciate the strength you feel about it.

Just a final question. Does the health system itself, we talked about the needs of people with learning disabilities to go to primary care and the observations required by support people, but does the health system itself respond adequately? Are people getting health checks, proactive health checks on a regular enough basis?

A. In some of the service organisations they are getting annual health checks. That requires a little bit of discipline to make sure that the health check is actually done annually, and the person isn't just ticking off last year's boxes. A number of the other agencies have nursing staff employed to monitor people's health. I personally feel that the annual health check, that research supports that position.

And I think at the service delivery, at the primary healthcare delivery end, you know, I go to a primary healthcare practice where I go and see my own GP every time I go

to the doctor, but somebody else goes to their practice and might get a different doctor each time, and I think that's particularly difficult for people who might have language, communication challenges as well as health challenges.

Q. Thank you, Dr Webb, I really look forward to your book.

CHAIR: Paul has asked some penetrating questions about the future. If I could just ask you to elaborate a little bit on the past so that we make sure we've got things right from you.

The first one relates to evidence that you gave that resonated with evidence that we heard yesterday about treatment in different villas and institutions, and the different levels of care and attention afforded to the residents in each of those, depending on the make-up of the staff, if you like, who was in charge, and it struck me from that evidence that there seemed to be a lack of oversight and setting of standards of care. Was that something that was prevalent in Sunnyside when you were there? In your case you're talking about wards, aren't you?

A. Yes, yes. Big villas similar to Templeton.

Q. Yes.

A. Typically within each ward or villa the charge nurse set the culture for the place. So we had one charge nurse who was into fresh air and what have you and by 7 o'clock every door and window in the place would be wide open, it didn't happen anywhere else, but, you know. And I think, and I have learned from Tony, that in other situations where the charge nurse is a violent person, then violence begets violence and it becomes the way of doing things.

Q. Yes.

A. You know.

Q. So that is consistent with what we heard yesterday.

A. Yes.

Q. And I think it's important that we hear it from more than one person if in fact that's the case. So that's the first point.

And the other part about this training officer, so not nursing staff, finds that there's -- and I think you've described it, the difference in roles and pecking orders, if you like?

A. Mmm.

Q. You've described that quite well, the fact that you as an outsider had some difficulties in relating to the nursing staff or persuading them about what needed to be done.

A. Yes, I had a cluster of key staff who were not necessarily well ranked within the service, but they were the people who had the influence, and I always got them on board first, and always took special care to make sure that when something happened and something really worked that they were the people that got the credit for it, that I tried to be relatively invisible in that sense.

Q. But you drove that, didn't you, that was your force of will, from my observation?

A. Drive slash manipulation, yes.

Q. All of that, coercion, whatever it took?

A. Whatever it took, yes.

Q. So the concept of a multi-disciplinary team working in the best interests of the residents wasn't something that was prevalent at that time?

A. No, and this is how we made a difference because we had -- I had an excellent OT and an excellent physio and was able to coerce excellent nurses, and so provided that little sort of hub, driving hub, if you like.

Q. Yes, thank you for that.

Another issue that came up yesterday was the complete lack of any dedicated medical, and I'm talking about general physical medical facilities in these institutions. Was that the same, like there didn't seem to be a hospital wing or a clinic or a place where somebody who was physically unwell was able to go and be healed?

A. In Sunnyside there was a clinic but our guys didn't go there. There were part-time people who were semi-retired from their medical practices would come along, and then on another occasion, because we had a ward for -- service for people with alcoholism, and I think on two occasions a GP who had been treated as an alcoholic got to the end of their treatment and just sort of moved to the other side of the desk and became -- well, it was easy for them to then work under supervision if they continued to work in the hospital.

Q. So if somebody at Sunnyside in these days, and I appreciate it's back then, but this is important, if somebody got ill, let's say they got the measles or broke a leg or something that normally would mean that you were cared for in a warm medical environment, were they -- they were just treated in their dormitories?

A. No, for injuries they would typically go into, in my time, would go into ED, and so would receive that emergency treatment there. We did have a specialist medical officer who, as I say, manned a clinic there for, really, bumps and bruises and minor sort of stuff, yes.

Q. Yes, okay?

A. In my 23 years at Sunnyside I don't remember any infectious disease apart from scabies, I think.

Q. That's interesting, isn't it?

A. Yes.

Q. A little bit of forward-looking before my final question, you referred to what seems a very tiny amount of training that medical practitioners get in disability issues. In your ideal world how would you see the training for such people? Are you thinking about a specialist area of learning, a specialist area for a medical person or are you talking about all medical people getting some good basic training, or maybe both?

A. To go to the extreme situation first, if you look at the UK training for psychiatrists, before they can sit their membership they have to do a year's work with people with learning disabilities. And my understanding is that UK-trained comprehensive nurses also have to meet a practice requirement like that working with people with learning disabilities. And we don't have those requirements.

I can't remember exactly what the, because it's an Australasian College of Psychiatrists. I think a few years ago they had their first examination question on learning disability and it threw a cat amongst the pigeons.

When I was at IHC, a colleague and I set up some medical training programmes at a number of different levels, but that was -- what we did with fourth year students at Otago was about an hour and a half. And we chose to use that time by having a parent talking to them about her severely disabled and autistic child.

Q. Right. So there's room for some improvement there --

A. Yes.

Q. -- by all accounts? Just to end from my questioning, the word that resonated through your evidence, whether you actually said it, you said it a couple of times, but it's the lack of respect --

A. Mmm.

Q. -- individual respect that seems to resonate through all the evidence that you've given. And that lack of humanity in the herding of residents struck a real chord. Listening today, I can't imagine anybody who's not shocked by that.

It shocked you but it wasn't shocking the people who were working there. I'm just challenging you on this a little bit. You say they were well-meaning people doing what was right at the time. But this was never right, was it?

A. No, not doing what was right at the time, but doing what was the order of the time and this was special. I mean, people would go away and they would live with their families and they would come back and they would live that style of living but then t hey would go to work and they would do this.

Q. Yes.

A. It's quite a split -- it's like a parallel, it becomes like a parallel universe.

Q. But it's a serious issue because, you know, you made the Nazi Germany comparison. We have to be very vigilant, don't we, about this? It's so easy to fall into patterns of behaviour and attitudes just because everyone else around us is doing that?

A. And it's more than just being vigilant, I think that there is a very real risk that in tough times when the dollar becomes harder to get, that this is the place where people, and I think in my evidence I cite a couple of examples, that this is the default mechanism that we can save money here.

Q. Yes.

A. And that to me is hugely risky.

Q. Or we can give this medication instead of taking a therapeutic approach, the short -- almost the shortcut version?

A. And I promise you, there will be pressure to do all of those things.

Q. So that's a challenge, isn't it, for the future?

A. Not that long ago I was involved, probably when I was working with IHC, I was involved with a very disturbed young man who was a boy and we were trying to find accommodation for him, and a senior person, whose name I don't know whi ch is great, from then Child, Youth and Family, was heard on the end of the phone to say, "For Christ's sake, there must be another four or five of these people around, can't we lump them together and bang them in a house?" And that's the risk.

Q. And it's almost the reality?

A. Mmm-hmm.

Q. You have set us a great challenge, Dr Webb, thank you. I'll leave you now with Commissioner Steenson.

COMMISSIONER STEENSON: Tēnā koe.

A. Tēnā koe.

Q. You've had a lot of questions so I'll just keep mine to a minimum, I've only got a couple. But I really want to get your views, because you've got such a lifetime of experience, so I want to take advantage of that.

So I guess I want to explore the social attitudes about people with disabilities and how that affects the services that are provided to them. Because you've talked -- in your evidence you've got the current issue we face is funding and that the disability sector is mainly focused on rationing and funding, individual support staff and services are fantastic but the system is not equipped to adequately support them.

So I'm just wanting to get your view on whether this, taking a step back at the social, broader social attitudes, would you -- what's your view on that, is it because society places value on a person's contribution in an economic way rather than valuing people because of their uniqueness as human beings, do you think that's related?

A. I'm not sure, it's a big question.

Q. It is.

A. It's a sort of meaning of life question. I don't think it's about productivity, I think it's about, well, it's sort of perceived worth. I mean, I'm involved with the support of people who cost close to $1 million a year to support, and there are some people who would say, "How can you justify that?" Now, I believe we can't justify not doing that. And I remind people that when somebody goes in for heart surgery or for a kidney replacement we don't say, "Is this person worth that?" You know, we do what is indicated given that situation and given the person, you know, it's too different -- I do remember one heart replacement that was deferred, but anyway.

I think it's -- it really goes back to Wolfensberger's time, when he found the ways that we respond to people who are different. Sometimes we feel sorry for them, sometimes we don't think they're worth whatever it is that, you know, they might require spent on them, sometimes we regard them as a freak. In some cultures people with disabilities are regarded as religious icons. But the psychology of it is that people who are somehow different are somehow passed through this process of judgement and evaluation.

I suspect it's a battle that will never be won, but that it's a battle that determines excellence of advocacy and vigilance and all the rest of it. I mean, I was blown away yesterday when Tony at the end of his recorded statement, because I'd forgotten about this, said, "Why can't people be kind?"

Q. Yes.

A. And, you know, and it's that loss of humanity and loss of citizenship and all of those sorts of things that we have to -- if we're going to support people with disabilities, then we have to do the whole nine yards, we can't cherry-pick.

Q. Thank you. It was a big question so you've answered it really well, thank you. And I think related to that is, I'd like your views on what are some of the social issues that occur by not providing properly-funded services for people with disabilities?

A. It always puts me in mind of the Dr Seuss Star-Belly Sneetches, you know, that have to go through the system and all get the same star in order to succeed. The risks are that we -- the real risk is we go back to exactly what we were doing 40 years ago. That's the real risk. Because if you start ignoring people's humanity, where do you stop?

Q. And what does that say about us?

A. Yeah. And, you know, it's -- and people who have people with disabilities in their lives will know that they are richer because of that, because, if you like, they get a non-tech non-complex expression of – go back to their humanity, to what they are, you know.

Q. Thank you. Thank you, that's wonderful. You've really provided a wealth of information today from your vast working experience, yeah, and describing the concentration camp like environment at Sunnyside. It's in line with lots of other witnesses' descriptions of these institutions, and just talking about the attitudes like we have held around people with disabilities and how they're being treated. What really stood out for me in your -- in what you've said today is the treatment being based on that animalistic conceptualisation of people with disabilities and being contained and to be restrained and using control and punishment, you know, that "us and them" power and control, rather than the care and the understanding that they deserve.

So yeah, thank you so much for providing your statement to the Royal Commission today, ngā mihi ki a koe.

A. Thank you.

MS BASIRE: Madam Chair, just before we finish, and I know this is out of order, but yesterday we heard about the drug experiment at Māngere.

CHAIR: Yes.

MS BASIRE: Dr Webb has mentioned to me this morning that she does have some information about that. I could ask a quick question to capture it.

CHAIR: I think it would be appropriate if you are able to do that, we'd really appreciate that, Dr Webb, thank you.

QUESTIONING BY MS BASIRE CONTINUED: Right. Now, without mentioning names, because it hasn't gone through some of our processes, we heard yesterday that at Māngere Hospital, about the same time that you were working at Sunnyside Hospital, there were drug experiments happening on the patients at Māngere. Can you tell us what you

remember learning about that, and I understand you know the doctor's name -- the professional's name, and can you tell us about being in a room and what he said about it?

A. Yes, and the person concerned left Māngere and came to Templeton and continued. I don't know the nature of the research, and I wouldn't like to over-embellish it, as it were. I suspect he was trying to find out how little medication or what different medication did different things. He was given carte blanche by the then prescribing medics to administer what fitted into his research design and I remember at a meeting with psychologists he chuckled and said, "It's great because the retards are one step higher than rats."

Q. Thank you, Dr Webb, I just wanted to capture that. Is there any questions arising from that?

COMMISSIONER GIBSON: Can I just check, so was there some experimentation continuing in Templeton at the time, or was this just reflecting on Māngere?

A. There was some because the same person came down and was replicating some of the regimes that he was using. But I wouldn't like it to be thought that, how can I put it, that he was giving people stimulants to see what happened to their behaviours, I think that he was manipulating drugs that were already being prescribed.

Q. Thank you.

CHAIR: Thank you, that's a very sombre note to end on, but very important that we heard that evidence, so thank you so much. I think it's time we all took a break, we're a little behind time but that's all right.

MS BASIRE: We are, Madam Chair, if we recommence at 12.00, we have Alison Adams with a pre-recorded interview, and we should be able to fit that in the time.

CHAIR: Excellent, thank you very much, we'll take the adjournment until 12 o'clock.

Adjournment from 11.46 am to 12.03 pm

ALISON ADAMS

MS BASIRE: Madam Chair, our next witness is Alison Adams.

CHAIR: Yes.

MS BASIRE: You can see Mrs Adams on the screen.

CHAIR: I can.

MS BASIRE: Her evidence is pre-recorded, she's watching from Christchurch. With her in support is her daughter Karen and her son-in-law Scott and in front of her she has two photos of her boys Malcolm and Nigel whose evidence she will be talking about.

CHAIR: Yes.

MS BASIRE: The photo that you can see on our left is a photo of Malcolm and Nigel aged 16 and 17, and the photo on the right is a photo of Malcolm and Nigel aged 61 and 62. So I've explained to Mrs Adams that what we will do is we will watch her video and then there may be some questions from the Commissioners.

CHAIR: Okay.

MS BASIRE: Mrs Adams' evidence will cover her sons Malcolm and Nigel, their time in Templeton, the abuse and neglect that they suffered there, their time in Brackenridge and their current life. Mrs Adams talks about a subject that we've heard a lot about, which is the constant struggle for funding and finding staff for her children.

Thank you.

CHAIR: Welcome, Mrs Adams. Thank you so much for taking the time and the effort and indeed the moral fortitude to prepare the statement that you've given to us. I can assure you that we have read your written statement and we're very keen to now see your video presentation. So thank you very much for coming. Can I also note, have you got Karen and Scott there?

A. Yes.

Q. That's good. Thanks to them, although they're out of shot, we're grateful to them for supporting you today and we're also of course thinking very much about Nigel and Malcolm as we listen to your evidence, so thank you.

We'll now play the video.

A. Thank you.

[Video played]

A. I'm Alison Adams, mother of Malcolm and Nigel. A lot of people will have seen them on television before. They're both intellectually handicapped as well as autistic, so they have dual diagnosis.

Q. How old are you, Alison?

A. I'm 86, will be 87 in two more weeks.

Q. And how old is Malcolm?

A. Malcolm will be 62 in February and Nigel, he's 61 in April, so it's all rolling around.

Q. How old were the boys when you learned that they had intellectual disability?

A. I took them to a child specialist when they were two and three and was told that they were just slow talkers, and that was because they'd been going to kindergarten and the teacher had requested it, they'd had a hearing test, etc, that had been fine, but they weren't talking. And at that time I was told by the child specialist that Winston Churchill was a slow talker,

he didn't talk until he was six. So not to worry, they will eventually. But of course it never happened, they are nonverbal, but they have picked up on some sentences which they say repeatedly. It's called “echolalia”, which they do, but they do understand everything that's said to them.

Q. So when they were about three and four years of age, they were assessed by Dr Marshall; is that correct?

A. Yes, when they were three and four I took them to see Dr Marshall who was also superintendent of Templeton centre. He at that time said that both my sons were severely intellectually handicapped and autistic and to put them in Templeton and forget I ever had them.

I couldn't do that, I just couldn't believe what he was saying, because my sons had won baby shows, because back in the ’60s you had your carnivals etc and a lot of baby shows, that sort of thing, and they looked normal, and they were going to kindergarten, they hadn't had a problem. But he said no, put them in Templeton, forget you ever had them. And that wasn't for me.

At the time, I was divorced, I was on my own with the boys and I was working three jobs, I'd taken in boarders to make ends meet because I wasn't getting any money from my ex-husband, and it was hard. I quit my jobs at that time while I dealt with it and decided I can change things and I decided to open up a children's day nursery, which I went ahead and did -- my boarders left -- and then when I was home with them, but they continued to go to kindergarten.

But then the psychologist came on the scene and he went to the kindergarten and he turned around and said they had to go to Ferndale school, they had to leave the kindergarten. Ferndale was for the intellectually handicapped at the time, there was nothing around for autism back then.

And so I had already booked them into a "backward" class at the North Beach School, the teacher was happy to give them a trial basis etc, but he wouldn't hear of it, and that's where things started to go wrong, because the boys hated that school, and there wasn't anything I could do about it, because they had to go to school, that was all. Yeah, I thought it was wrong then but from that day on it was all downhill right through their lives.

Q. Right.

A. And it was when they were 15 and 16 my back gave out on me, I had surgery, the surgery was not successful, so I have lived with shocking pain ever since I was 38, 40, and I had no choice but to put the boys into Templeton.

Q. "In 1968 Alison married her second husband Laurie, he was in the United States Navy stationed in Christchurch. Laurie adopted Malcolm and Nigel. This enabled Alison to put Nigel at the private Hōhepa School during the week and he was home at the weekends.

In 1970 Laurie had to return to the US to serve out his contract. Alison was not able to get visas for both Nigel and Malcolm and so made the decision to leave Nigel in New Zealand at Hōhepa school and go to the US with her daughter Karen, and Malcolm.

In 1973, Mrs Farrow, who ran Hōhepa school, died. Alison received word if she did not return to New Zealand, Nigel would be put in Templeton. She returned home and the boys lived with her and Laurie until they were 17 years old."

When you came back to New Zealand, what did you notice about Nigel and the skills he had learned at Hōhepa?

A. He sewed beautifully, he ate beautifully, his hyperactivity had disappeared, he was a perfect little gentleman actually. When he ate his dinner his little pinkies would stick out, he was quite something.

Q. What about his verbal skills, had he learned words?

A. No, they hadn't improved except with singing.

Q. Right.

A. And he was talking because the carers at Hōhepa at that time were Dutch, German, and it was run on the Rudolf Steiner method. He was talking in German, Dutch and English when he did come out with things, but singing, he'd sing songs beautifully. He doesn't do much of that anymore, but sometimes I can talk him into it.

Q. When Malcolm was in the States, what was his functioning like with you in the US?

A. Good. He had it good over in the States. He went when he was eight and we got him into a school called Happy House and it was only five to a class. So with that, he -- with the teacher and an aide. So he got plenty of attention, etc, and he was in the US Special Olympics for running and softball throwing, and he came second, got a certificate for that. And it would have been when he was about nine.

So he had a good life over there, the school was for autism etc, and he was doing very well.

Q. How old was Malcolm when he went into Templeton?

A. Went into Templeton, he was the 17 going on 18. It was before Christmas, my daughter was getting married and Malcolm was very hard to manage, he was a very angry young man, he was going around smashing windows, etc, at home, because they were home from

the time they were 15 and you couldn't take them anywhere because they'd walk straight out in front of a car, you had to have control of them.

Q. He went into Templeton on a full-time basis?

A. Yes, in the February.

Q. In the February. Now, I understand that you went out to see him after about two weeks. What did you first notice?

A. Oh, he'd been turned into a zombie, he'd been put on drugs, he couldn't even stand. He was lying in his own urine. I had been told by Templeton not to come out for six weeks and after a couple of weeks I had to go, I had to make sure he was all right, and that's what I found.

Q. Had anyone asked you for permission to put him on medication?

A. No.

Q. Had he been on medication before that?

A. No. He'd never been on any medication at all.

Q. What happened when you saw him in that state, what did you do?

A. I blew my stack at them and said, "This isn't good enough, he shouldn't be on medication, I managed him for 17 years without medication, so why is this happening?" And they said, "Oh well, it's to make life easier for the staff." I said, "What?" I just couldn't believe it. I mean, that's their job to look after them. In the grounds he can go for a run, do whatever, take him down to the swimming pool, but you don't put them on drugs.

I told them I wanted him off it, he'd never been on any before. They did take him off and they moved him to a different villa.

Q. When he was initially in Templeton did he come home for the weekends?

A. Yes, they came home every other weekend from Templeton. We'd go out and pick them up on the Friday night, they'd be home until the Sunday, we'd take them back Sunday afternoon.

Q. Now I want you to tell me about the time that you went to get Malcolm for the weekend when it was his birthday, what did you discover?

A. It was terrible. Went out to get him, it was his 20th birthday and nobody had phoned us, we got out there and found his head had been split open, it was all stitched, his eyes were black and blue, his nose was broken and he had welts all over his body. He was a mess. And I exploded and demanded to see the doctor. The doctor said, "Well, you won't let us put him on drugs." I said, "What the hell's that got to do with it?" I said, "That's nonsense."

So I wasn't getting anywhere with the doctor that was there, so we took him down to the Police Station and the Police doctor examined him and said he'd been viciously beaten with a weapon. The Police looked for a weapon but they never found one. And it just got forgotten about.

Q. To this day do you know whether it was -- who beat him?

A. No, but it did happen again a couple of weeks later to another person in the villa that I heard about from the staff member, and that boy died. So it was something that was happening out there a lot. There was a lot of abuse and my boys in particular, they were put in different villas, they wouldn't let them be in the same villa, and they were coming home with all sorts of things happening to them, bruises in their ears and sometimes teeth missing.

No, it just wasn't good enough. I complained and pretty much got told "It is what it is" type thing. Yeah, it was very hard.

Q. What did you find the Police's attitude was like when you reported the beating?

A. Well, their attitude was -- yeah, what had happened, Nigel had gone missing in his pyjamas one night out there, couldn't be found, and the Police were called to look for him. Laurie went out there. I got asked by the Police would he try to convert a car? I said, "No way, but," I said, "look at him, he loves cars, he could be in one." And I said why haven't you brought out a dog to look for him? "Oh, we might need the dogs in a burglary, we can't be bringing them out here." I was absolutely shocked.

My husband went all over the Templeton area looking for him and we had no luck in finding him. The next morning -- in fact, I thought somebody had run off with him. I did hear a rumour that somebody else went missing from there and was never found, so I was in a state at the time.

This isn't easy. And Nigel the next morning was found by a staff member out the back of Templeton, he'd been out there all night, was found about 9 o'clock, my husband was already out there, so he brought Nigel home to me, and he was freezing, it was a cold night, and so -- and all he would say "birds, birds fly in the sky", and that was him being out all night, he was hearing different animals, but he also has a lot of night terrors, I think some of that might have been involved.

These guys haven't got over all the stuff that happened to them by any means. He also suffered malnutrition out there, he wasn't -- because he ate beautifully, he wasn't getting any food to eat because the other residents were grabbing the food off them, he was

going around hungry and he went from 10 stone down to seven stone in a matter of a couple of weeks.

I took him off to a specialist outside of Templeton, "Well, he suffers from malnutrition" and he wasn't getting enough to eat. So of course I went out there, raised hell again, and I even started going out there every day to make sure that he got fed, because -- and that he sat at a table on his own to eat his dinner.

Q. When Nigel went missing that night, did Templeton have any explanation for how they'd managed to lose him?

A. No, they didn't. And he wasn't found until the next morning. I was annoyed with the fact when they found him he was still in the Templeton grounds, therefore a Police dog would have found him. So I put a complaint in to the Police and next I got a call from one of the police officers and I said to him, "You should have had a dog out that night, my son would not have spent the night in the open if the dog had been brought in, he'd have been found." And he said to me, "Well, we can't be out there every five minutes", but he was going to look into it. He looked into it, got back to me, and that was his answer, he said, "If either of your sons ever go missing out at Templeton, we will have a dog out." I said, "What about the rest of the other residents?" I said, "It can happen with them too." "Oh, we can't be out there every five minutes."

I mean, it's one rule for the so-called normal, it's another rule when it comes to the handicapped.

Q. So at the villa that Malcolm was in, there were day rooms?

A. Yeah.

Q. Can you talk to me about the effect on Malcolm both physically and emotionally about the day rooms?

A. Well, it was the same effect really on both of them, Malcolm and Nigel. There were no toilets off of the day rooms, so they couldn't get to the toilet and it was always -- they were just great big rooms with chairs around them, and they couldn't get to the toilet. So they had no choice but to wet their pants, if they tried to go out the door there was a guard on the door to say, "Go sit down, you can't come out" -- Hey, Mal, eh?

So of course, now they're incontinent. Everything that they had learned by living at home had gone out the window. They had to start wearing pads for their incontinence, the ir speech or the state where it was at it didn't improve any, they had nothing to do. The only thing that was good about Templeton was the fact they had a swimming pool that they were taken down to, they had the workshops where a lot of them worked, they had a printing

shop, they had horse riding, which Malcolm did. Nigel's not an animal lover by any means but Malcolm is.

And out in the grounds of Templeton there was plenty for them to do, but they were stuck in those day rooms. They even had a trampoline outside one villa that they could go on. But no, they were stuck in those day rooms all day every day.

Q. Was the day room locked?

A. It had a guard on it, they weren't allowed out. If they wanted to go to the toilet, there's no way, they just wet their pants and what have you because staff weren't toileting them or letting them out to go to the toilet.

Q. What does Malcolm say about the day room, is the day room still part of his memory of Templeton?

A. It is. When he's in a bad mood, if he's in a bad mood he'll point to the staff, "Get in the day room, get in the day room", and he'd go on about it. This is when he's in a bad mood, if his mood is good you don't hear it as much, but, yeah, it comes out when he's angry.

MALCOLM: The day room, day room.

A. Yeah, you have the day room, you went through a lot, didn't you, eh?

MALCOLM: (Inaudible).

A. You went through a lot, didn't you, Mal?

MALCOLM: (Inaudible) in the day room, day room.

A. You don't want to go in the day room, do you?

MALCOLM: Yeah.

A. No, not a nice place. You liked going swimming, which you don't get to do, eh? You like swimming? That was good fun, and you liked horse riding?

MALCOLM: Yeah.

A. You used to go horse riding?

MALCOLM: Yeah.

A. There was one time he was out horse riding and the staff member that was leading the horse around the paddock, she was talking to him but wasn't looking at him, she was looking where she was going, all of a sudden she turned around and looked and Malcolm was gone, he'd slipped off the back of the horse and was way down the yard.

MALCOLM: (Inaudible) day room.

A. We have some funny moments, don't we, Malcolm?

MALCOLM: (Inaudible).

A. You remember getting off the horse?

MALCOLM: Yeah.

A. Did you get off the horse?

MALCOLM: Yeah (inaudible).

A. They talk their own lingo, eh.

Q. So as you were explaining, Malcolm and Nigel were in different villas and they were effectively locked in a day room?

A. True.

Q. Did you notice with Malcolm in particular a change in his behaviour to do with sexual activity that occurred when he was in Maple Villa?

A. It wasn't -- with Malcolm, the sexual problems were in Totara. He was in Totara Villa at the time, and yeah, when I brought them home on the weekend and showered them in the morning, both guys were actually backing off of me in the shower, Malcolm was in Totara and Nigel was in Maple, and I thought this isn't right, when I'd come to wash their private parts they'd back away. I knew something was going on. And at that time I had heard from a staff member out there that the charge nurse of Totara used to get a kick out of watching the residents react sexually to each other and I thought I've got to move him.

So of course I called the charge nurse of Maple Villa where Nigel was and I said to him, "Have you got a spare bed?" And he said, "Oh, I'll have to think about that one." So he called me back and he said, "I've made room for Malcolm's bed to come down here", and he said, "It's up to you to talk to Dr Marshall about it." So with that, I went to Dr Marshall and I said, "I want my sons together" and he said, "No room at Maple", and I said, "Well, I've talked to the charge nurse there and he said he can fit Malcolm in there.

So, with that, I got my own way and Malcolm moved to Maple. The day Malcolm walked into Maple I knew I'd done the right thing. They were happy to see each other. They've got a relationship that -- you've got to be living with them to see it, but they like to be together. They quite often hold hands when they're out and about type thing, it's quite lovely to see.

Yeah, but before that even happened, Malcolm, it was after one Christmas when I took them back that they -- because they used to come home for a week at Christmas and I took them back and I phoned up to say I'd be out that weekend to get them, and lo and behold, they'd put Malcolm in Sunnyside. What?

Q. And Sunnyside is a psychiatric institution?

A. That's right. And I couldn't believe it. They said they couldn't manage him, they'd sent him to Sunnyside. So, with that, I went to Sunnyside, I found my son had been placed on a

mattress in a cell, he was in the foetal position and he was medicated so highly he couldn't move, he couldn't do anything. And I had a go at Sunnyside, I said to them straight, "How did my son get here?" And he said, "Oh well, he was playing up." Evidently when I took him back after that Christmas he had played up on them and that's what they did.

And I said, "Not on, he's got to go back to Templeton." And I said, "What medication have you got him on?" He was put on a medication called Haloperidol, which -- he's autistic, he should never be put on any brain-changing medication, because being autistic he has low dopamine levels and with low dopamine levels in the brain they become medically fragile when you put them on pills that they use for schizophrenia, that sort of thing. And he had become medically fragile at the same time.

And of course Malcolm is an epileptic due to the beating he took earlier in his life in Templeton, he'd become an epileptic, which meant he -- where am I? Which, again, you had to be careful what medication you gave him, if his dopamine levels fall he can have a seizure. So as long as he's never given any brain-changing medication, we managed to keep his seizures at bay with the medication he's on. So I was angry.

Q. Did you manage to get him back to Templeton from Sunnyside?

A. Yeah, I have called Templeton and said, "I'm bringing him back." I couldn't take him home at that time because he was angry, he was on medication which was bad for him and the doctor said he had to come off slowly of that medication he was on. So I ended up having the staff help me get Malcolm into the car and I took him back to Templeton. When I got to Templeton, I found they were -- they had the door off of the room, they were putting a glass window in so they could lock Malcolm up in there and watch him through the window in the door.

Q. So they were going to lock him in seclusion?

A. Yeah. And I didn't like that, but he had to come off that medication so it -- and while he was coming off that medication, he was peeling the ends of his fingers, the skin, and he was doing it to his toes as well, and just tearing the skin off his toes. And I said to them, "Why didn't you put socks on him? You're going around barefoot anyway." So you've no idea what I went through.

So once I got the medication he'd been put on down I took Malcolm home for about a week, but he went around smashing windows and all sorts, and it was hard, and of course we were into, at that time, Templeton closing.

Q. So just before we go into Templeton closing, I want you to tell me about the time that Malcolm had to go to hospital for an erection?

A. Oh, yes. I had a phone call from the staff member who said that Malcolm had had an erection for over five days and I was quite shocked. I ended up -- she sort of told me on the quiet and I ended up calling up an ambulance and getting him to hospital. I met him at the hospital and it was shocking. Anyway, the doctor at the hospital said he'd have to be operated on. They had tried to get it down but nothing was working so he went in theatre and was operated on and he came out of theatre and he came to, lo and behold, the operation hadn't worked, so he had to go back and have a second operation.

The doctor said to me, "It may not work again", I said, "That's fine." But it still does and Malcolm won't leave it alone.

Q. Before he was in Totara Unit, had he had any pre-occupation with that area of his body?

A. No.

Q. And how old would he have been when this started to emerge?

A. This was in Totara that it started. He -- Malcolm never bothered with anything like that, when he went into Templeton that's what happened. Nigel never bothered either, it was something they just didn't do, they didn't masturbate. But now with Malcolm it's all the time. He can't live with anybody else because of it.

Q. What do you think triggered it?

A. Mmm?

Q. What do you think triggered Malcolm's obsession with that area of his body?

A. Being abused, yeah. I believe he was abused a lot and that created that, because as a teenager he never worried about it, even as a child he never played with it or created an erection, just didn't happen. It wasn't until he was interfered with that it happened and he was abused. I mean, I have nightmares over it, so Lord knows what they have.

Q. Particularly after that operation, did you challenge Templeton as to what was going on in those day rooms?

A. Yes, I did, but that's why I managed to get him moved to Maple with his brother, because of what had transpired. I didn't want him back in Totara after his operations, etc.

Q. And what was the difference with the Maple unit? I understand it was the charge nurse who ran Maple unit that gave you confidence that Malcolm would be better off?

A. He had -- the guys in Maple were known as "The Maple boys" and John the charge nurse, he had them out for long walks. I mean, Templeton grounds are huge and he always had those boys out morning and afternoon for long walks which they really enjoyed, but were criticised by the other villas for it, which is ridiculous, they just probably didn't want it to

become part of their lives, but John was a good charge nurse, and he did try to work with the boys and get them ahead in a lot of ways.

But the day rooms were the problem, weren't they, Malcolm? Horrible the day rooms, eh? Taking you back in time too. That's the way it was back then.

Q. With Nigel you said that you'd noticed a change of behaviour when you were showering him when he was home for the weekends?

A. Yes.

Q. Do you also believe that he had been sexually abused at Templeton?

A. Yes, yes, I do. I mean, they never did that before when I went to wash them. I mean, they'd turn around, etc, in the shower for me, but no, they wouldn't, they'd just back up to the wall.

Q. In terms of abuse, did you witness any direct abuse by staff on residents when you were out at Templeton visiting?

A. No, they're not going to let you see it happen, but it does happen.

Q. What about the male staff member who used to sit at the door of the day room with his walking stick?

A. Yes, he had a walking stick which I did see him use that, he's sitting in the doorway of the day room, I actually walked up behind him to get the boys, because they were in there, and I saw him bring the stick up because Malcolm, as soon as he saw mum, he started to run to the door, and of course the guy that was sitting there, he brought the stick up to stop him -- he hadn't seen me -- and I said, "What are you going to do with that?" He turned around and looked and said, "Oh." I said, "I've come to get Malcolm and Nigel", and I got them out to the car, but yeah, he used that stick I would say.

MALCOLM: (Inaudible).

A. All right, Mal?

MALCOLM: (Inaudible).

A. Yeah.

Q. And did you hear staff members swearing at the boys?

A. All the time, and Malcolm picked up a lot of the swear words out there, it was rather hard to take him anywhere without it coming out of the mouth. Yeah, they did, one in particular.

Q. What sort of words did you hear the staff say at the boys?

A. I'd rather not use them. "Bastard" was one, the F word of course, that came out a lot, and not very nice if you've got them out in the community and those words come out of their mouth, you know, but it was taught to them by the staff. I even heard those words out at

Brackenridge as well, and some of the staff that had been in this house I've heard that word, and I've told them not to use it because Malcolm was picking up on them.

Q. "In 1998 Templeton closed permanently. Alison at the time opposed the closure of Templeton as by the 1990s she felt the staff had improved. Her preference was to keep the positive parts of Templeton, the large grounds, the swimming pool, the Riding for the Disabled, the community hall etc, but build purpose-built accommodation for the residents. When Templeton was closed, a small portion of land was used to house some residents. This was called Brackenridge. Malcolm and Nigel lived on the Templeton grounds at Brackenridge for 10 years from 1998 until 2008. In 2009 Alison bought their boys their own home."

We know that the boys were at Brackenridge for 10 years from 1998 to 2008. At this stage you were really frustrated?

A. Yes.

Q. Templeton's closed, nobody heeded your warnings?

A. True.

Q. The boys are unhappier in Brackenridge than they were at Templeton?

A. True.

Q. So what was your solution?

A. Well then, I got to thinking and especially about them moving into the community, it wasn't something I was thrilled about, but I thought well, if I can do it my way and if I can get control, then maybe it could work. So my husband backed me on it and we decided to buy them this house, so I went and saw the manager at the time at Brackenridge and said to him, "Okay, what if I move my boys?" I knew he wasn't going to ask me to do it, so I asked him, "What if I move my boys out into the community and you staff the house?" And I told him how to get the funding for it.

Q. Can you explain initially the house, so you bought the house?

A. Yeah.

Q. So you and your husband raised a mortgage?

A. Yes.

Q. On your own home?

A. Yes.

Q. And you bought this house?

A. Yes.

Q. And then the deal was that Brackenridge, who get funds from the Government, would then fund the staff and the rental of this house; is that correct?

A. True.

Q. But things have gone awry in terms of funding, haven't they, right from the word go?

A. Yeah.

Q. So before we talk about the funding issue, can you tell us what is really good about the boys living in their own home?

A. Oh, there's a lot of good, they get out and about. It's like this past weekend they went to Diamond Harbour, they went out on a boat. You wouldn't get that if you were still in Brackenridge, you would be just sitting in that house doing nothing.

The staff are very good about getting the boys out and about. If I want them brought around to me because of my age and my state of health, it's not that easy for me to come around here, but they'll bring them around and drop me off and spend time with mum every other weekend as a rule. They've got their own rooms, they don't have to worry about people coming in, invading them.

I think it's lot better, I think they do too, I think they accept that this is their home and it's their home for the rest of their lives. That's what's important.

Q. And the only two residents are Malcolm and Nigel, is that correct, here?

A. Mmm?

Q. The only two people living here full-time are Malcolm and Nigel?

A. Yes.

Q. And staff come and go?

A. Yes.

Q. One staff at night and two during the day?

A. That's the way it's supposed to be, yeah. They've tried to take me down to one staff, but no, I haven't accepted it. I feel after all they've been through, all the abuse they've suffered, that's the least the Government can do, is supply them with two staff to be looked after properly.

Q. And their needs assessment back in 2008 said that, that they needed one-to-one care, didn't it?

A. Yes, mmm, because all that abuse affects them. Nigel still has night terrors. He still loses the plot every now and again. And the same with Malcolm. They go on -- they haven't forgotten and they're not going to forget, I can't forget what's happened to them, and they had to live through it.

Q. In terms of the ongoing effects, just focusing on Malcolm, what's Malcolm like with men that he doesn't know?

A. He's very cautious. He reads -- both boys read body language and they pick up very quickly on who they like and who they don't like, which means that mum picks up very quickly as well. So that I'm very cautious about what staff are brought into the house, and I've got a new team leader now and he'll be the same, he'll be very cautious who comes into the house. He's just getting into an understanding what's been happening with them.

Q. What do you think the biggest impact on Malcolm has been from his time in Templeton?

A. They're more manageable now than what they were, moving into this house, they're happier, they're more relaxed. Malcolm most of the time used to shake like a leaf, he's not doing so much shaking, are you? And of course Nigel still has his moments of going off. They both do. Malcolm will have his grizzly days, just like all of us, we have our good days, we have our bad days, and they do too. But they're more relaxed.

And some nights are bad for Nigel, and it all comes down to their memory. They have to live with it, and I'm having to live with what's happened to them, and the guilt of having let it happen, which I had no control over, but they deserve what they've got now, they deserve -- they're 60 -- you'll be 62 next month, Nigel will be 61 in April, they deserve to have a comfortable life for the time they've got left.

Q. So the funding struggles, just briefly, I want you to be able to explain what you've explained to me how it's a constant battle about the funding, and what the issues for you currently are for funding?

A. Yes, it worries me. I would like it to go away. I feel the boys deserve whatever funding is needed to run their lives after what they've been through. They should never have been, from kindergarten days onwards, they should have had a better life, which I couldn't give them because of my back surgery, but that's what should have happened.

Q. So Alison, you're about to turn 87, and you must be really worried about the boy's future --

A. Yes.

Q. -- when you're no longer around. What do you want to tell the Government?

A. I want the Government to fund it. I got told 14 years ago it cost $1 million to keep a prisoner in jail, so what are they bitching about? Pay up the funding that's needed to keep my sons in with the life they had. They didn't pay for the house, I did. And I've spent a lot of money over the years to meet their needs, and surely they can do that with the staffing of the house."

MS BASIRE: Madam Chair, that brings us to end of the pre-record. And Mrs Adams is happy to take questions.

CHAIR: Thank you. Mrs Adams, I appreciate that must have been rather difficult for you to sit and watch. We do appreciate that and I hope you don't mind, I think we have got some questions. Is that all right.

A. It's fine.

Q. Good on you.

COMMISSIONER STEENSON: Hello, I don't have any questions, I just want to say thank you very much for your witness statement today, thank you.

CHAIR: And Paul Gibson.

COMMISSIONER GIBSON: Thank you, Mrs Adams. Thanks for your statement and thanks for your courage and advocacy for your sons over so many years, and I hope we're able to influence the struggles you have around funding for support and services, but also my question is about redress. Have you and your boys ever had any redress or compensation, any well-being support for what happened to them and to you over the years, both through either Ministry of Health or through the Education Department?

A. Well, there is the fact that they didn't get any schooling, they got no autistic training. Throughout all their life really, they've been with intellectually handicapped instead of getting what they should have got. I mean the age they are now, it's too late for anything. But they should be funded appropriately which they certainly are not. It's a matter of -- you'll have to excuse me because I am old, and I forget things at times, but the funding is important. Their needs need to be met with all of them, it's not only my sons, it's all of those out there need to have their needs met, meet their needs and their funding will follow.

Q. And has there been any support for you and your well-being now or in the past?

A. I didn't quite hear that.

Q. You've experienced a lot as well because of what has happened to your sons, has there been support or funding or compensation for you or any support or counselling for you and your well-being because of what you've experienced over the years?

A. I'm not interested in getting any financial support. What I want is for the funding to meet the needs. At times, like with my two sons, they can't live with anybody else after what they've been through, and I keep having it from Brackenridge, etc, there should be three in the house, maybe four. This is not on. It's just the two of them, they're happy, and as long as we've got the staffing we're fine. And when they went through LifeLinks, LifeLinks did

state they should have two staff during the day and one at night. They need to meet those needs.

As I say, you meet their needs, the rest will follow. But when the funding is so short. I mean, I got told two years ago you're 70,000 over in your funding. I don't need to hear that sort of stuff, they've been through enough, for God's sake fund the service properly. If you fund it properly, then their needs will be met. There are times when two in a house should be acceptable, especially when they've been abused. And then there are times when three could be, or even one. Fund it properly, as I say, and their needs will be met.

Q. I agree. Thanks so much, thanks Mrs Adams.

CHAIR: Just one question or area of questions from me. We've heard in other parts of our Inquiry, particularly in relation to children and their families, that the best thing for families is to be kept together, that children thrive when they're kept together and that the attachment between not just children and their parents but between their siblings, brothers and sisters, is really important for their well-being.

You have described today how you fought to get your two boys to be in the same place. That sounds as though it was very important; is that right?

A. It is very important. I mean, my sons all these years have been coming home every Christmas, they still believe in Santa Claus, and I've got now five great grandchildren, I've got three grandchildren, five great grandchildren, and they're always -- the boys come around every Christmas to my daughter's house and they spend Christmas with them, that has never missed a year, and it is important.

Q. Yeah. It won't surprise you to know that one of the professional people who've talked to us have said that the most important factor for the well-being of disabled people living in the community is connection with their family. Would you agree with that?

A. I would definitely agree with that. I think it's important in a lot of ways for the growing of the family if they have to connect with the handicapped person at the same time. I think it brings out the best in them.

Q. Thank you for that.

Mrs Adams, you are one of the amazing women we've heard from this week and I think we'll be hearing from some more and that is the mothers, and we salute you. Thank you so much -- you're making me feel emotional because I feel so touched by the efforts that you've gone to.

A. Well, Malcolm and Nigel do give back a lot.

Q. Yes.

A. The reason I'm still alive today --

Q. Yes.

A. -- is because of the time I spend with them. They come around every other weekend still and it just -- things they come out with, like last weekend Malcolm looked at a fire screen that I made years ago and he said, "It's a horse", and he's never said that before.

Q. Yeah.

A. There is new language coming with them and it's to do with the new staff I've got, I just don't have enough of them.

Q. Right. Well, you can be extremely proud and we are very proud of you too. So thank you so much for giving your effort, your time to your boys, and thank you for sharing that with the whole of New Zealand who needs to hear this story. So thank you very much indeed.

A. Thank you.

Q. So good bye.

A. Thank you, judge, bye bye.

Q. Not at all. Good bye.

Time to take a lunch break, I think. What time shall we return? I think at the moment it is --

MS BASIRE: 2.15 will be fine.

CHAIR: Is that fine, 2.15?

MS BASIRE: Yes.

CHAIR: All right, we'll take a break to 2.15, thank you.

Lunch adjournment from 1.09 pm to 2.15 pm

CHAIR: Welcome back everybody to this afternoon's evidence. Mr Thomas, we're having a video first and I think can I see Peter on the screen?

MR THOMAS: That's right, Madam Chair. I thought we'd perhaps have the video and then introduce Peter following that if that's okay?

CHAIR: That's fine, all right, let's have the video then.

PETER KEOGHAN

[Video played]

MR THOMAS: Thank you Madam Chair. Peter Keoghan is the next witness who's here on AVL [Audio Visual Link]. Do you want to introduce yourselves perhaps?

CHAIR: Yes. Hello Peter.

A. Hello.

Q. Hello, my name's Coral Shaw and I'm on the Commission and I'm here with -- you can see Paul over here, can you see Paul?

A. Yeah.

Q. Paul Gibson, and over here is Julia Steenson.

COMMISSIONER STEENSON: Hello.

CHAIR: And we're here to listen to what you have to tell us, and we're really looking forward to hearing from you. So they're going to play the video that was made and then we'll hear it.

MR THOMAS: I'll just give a brief introduction if that's appropriate, Madam Chair?

CHAIR: Of course.

MR THOMAS: I'll just mention who's there with Peter. So Peter Keoghan's here via AVL from Whangārei. Peter's supported by his PASAT [Personal Advocacy and Safeguarding Adults Trust] navigator, Emma Neilson and also a staff member, Cheryl, who supports Peter at his rest home where he currently lives in Whangārei.

CHAIR: Thank you.

MR THOMAS: Peter's evidence relates to his time at Tokanui Hospital, the former psychopaedic hospital. He was there from 1961 to 1984 from around age five years old into his 20s. And Peter's pre-recorded evidence will describe the abuse and neglect that he witnessed there. Thank you Madam Chair.

CHAIR: Thank you.

[Video played]

"Peter Keoghan is of Pākehā descent and is a wheelchair user and cannot use his hands. He was a resident of Tokanui Hospital from an early age until his 20s, 1960s-1980s. Peter is wearing a check blue-collared shirt and sunglasses; he's sitting in a slightly reclined position."

QUESTIONING BY MR THOMAS: So we're at [GRO-B] in [GRO-B] in Whangārei and my name's Michael Thomas from the Royal Commission and Ella Maiden's also present. And we've got Peter Keoghan and we've also got Emma Neilson here present. And Peter, we're here today to take some pre-recorded evidence from you.

A. Yeah.

Q. And before we start that, I'm just going to ask you to basically take the oath, so I'll read this out and then you can confirm that you're happy with it. So do you solemnly, sincerely and truly declare and affirm the evidence you will give to the Royal Commission will be the truth?

A. Yes.
Q. Thank you. Okay. So we'll just start straight into the questions Peter, if you're happy with that?
A. I'm happy with that.
Q. Great. So do you want to just tell us what your full name is and your age?
A. Peter John Keoghan.
Q. And how old are you?
A. 60.
Q. And can you describe for us what your disability is?
A. I can't remember.
Q. That's okay. You use a wheelchair?
A. Yeah.
Q. And you can't use your hands?
A. I can't use my hands at all. I can't walk either.
Q. Yeah. And you've got limited sort of vision with your eyesight?
A. Blind.
Q. Blind, yeah. Thank you.
A. That's all right.
Q. Peter, just before I ask you some questions about your time at Tokanui Hospital --
A. Yeah.
Q. -- can I ask you, can you tell us about where you lived before that?
A. I lived in Te Aroha.
Q. Who did you live with?
A. My mum and dad.
Q. How did you come to be at Tokanui Hospital?
A. My mum put me there.
Q. Yeah. Do you know why you were taken there?
A. No, I don't know anything about it.
Q. Yeah. Do you know how old you were at the time approximately?
A. I don't know.
Q. Were you a young boy?
A. Yes, I am.
Q. So I'm going to ask you about your time at Tokanui Hospital now, ask you some questions about that.

A. Yeah.
Q. So you can't remember exactly how old you were, but do you think you were a young boy, does around five or six years old sound about right?
A. Yeah.
Q. And you wouldn't recall what year that would have been roughly?
A. I don't know.
Q. That's okay. We've got it in your written statement, it was around 1962 or '63. Do you know how long you were at Tokanui approximately?
A. Four years.
Q. Okay. I think we've got you, according to our records, you were there a bit longer, maybe 20 years?
A. Yeah. 20 years I was in there.
Q. Yeah? Does that sound right to you?
A. That's right.
Q. Yeah. What was it, can you describe to us what it was like there for you?
A. Like a bloody prison.
Q. Yeah.
A. That's all it is. Like a bloody prison.
Q. Yeah. How were you treated there?
A. Not very well.
Q. I was going to ask you Peter next, the next topic I was going to ask you about was I understand from your statement that you were placed in seclusion for some of your time at Tokanui?
A. Yeah.
Q. Can you tell us a bit about that?
A. I was locked up in the bloody -- in the side room all the time.
Q. Yeah. What was that room like?
A. Bloody terrible.
Q. Yeah?
A. Bloody cold like anything.
Q. Yeah. So it was cold, what else, can you recall anything else about the room?
A. It stink.
Q. It stunk?
A. Yeah.

Q. Yeah, why was that?
A. All the bloody water from the rain coming in, coming in there.
Q. Yeah, okay. What about, were you locked in there?
A. Yes, I was.
Q. Were you in clothes or what were you wearing when you were put in there?
A. I was in my -- I'm in my clothes.
Q. Yeah?
A. They let me out, they let me out though.
Q. Yeah, was there a bathroom in the room, do you recall?
A. No, there's not.
Q. Okay. Do you know like how long you would have been in there at any time, for any length of time?
A. I've been there all bloody -- all bloody day.
Q. So, sorry, I was asking you about that seclusion room, Peter, and sorry, I missed your answer, do you know like how long you were in that room for?
A. Long time.
Q. Yeah?
A. Very, very long time.
Q. Yeah. And did you have any activities in there or anything?
A. No, there's not.
Q. Yeah, so what did you do, just sat there or what?
A. Just sit down and lie on my bed and go to bloody sleep.
Q. Yeah, okay.
A. Looking at the bloody ceiling.
Q. Did the staff like tell you why you were in there?
A. No, they didn't tell me nothing.
Q. Could you get out of there?
A. I got out of there all right.
Q. How did you do that, or what happened there?
A. They left the door open.
Q. Yeah?
A. I went to the toilet.
Q. Mmm?
A. I look around and see any staff -- any staff around.

Q. Yeah?
A. I escape.
Q. Yeah, nice.
A. I escape out of there.
Q. And where did you go?
A. Back to work on the truck.
Q. Oh yeah. Nice.
A. On the laundry truck, rubbish truck.
Q. Yeah?
A. And the mail run.
Q. What was that, Peter, the last thing?
A. Doing the mail run with the paper.
Q. The mail run?
A. Mail run, yeah.
Q. Yeah?
A. And heavy drug boxes.
Q. Did you get taken back into the room or not?
A. No.
Q. No. When you were in that room before you got out, how did it feel to be in there?
A. Terrible.
Q. Yeah?
A. Terrible, terrible, terrible.
Q. So I'll ask you now just a bit more about other aspects of your time at Tokanui, if that's all right?
A. That's all right.
Q. Yeah, about those sort of -- what schooling you did and work and other activities. So am I right that you went to school there?
A. Yeah.
Q. Yeah. And do you know until what age approximately?
A. I don't know.
Q. Yeah. We've got it in your statement that until you were about 16 years old?
A. Yeah.
Q. Does that sound right?
A. That's right.

Q. Did you enjoy school at Tokanui?
A. Oh yeah.
Q. Yeah? What did you do?
A. Making guns, making guns, rifles.
Q. Making guns and what was the other thing you mentioned?
A. And rifle.
Q. Rifles, yeah?
A. Woodwork.
Q. Woodwork, yeah. Were the guns and rifles woodwork?
A. That was woodwork, yeah.
Q. Was there anything else you recall doing at the school?
A. No.
Q. Did you do other activities at Tokanui, like pub quiz and bingo?
A. Have gymnastics there.
Q. Gymnastics?
A. Yes.
Q. Yeah, tell us about that.
A. I do the somersaults.
Q. Yeah? Was that part of your schooling or just an activity that you did there?
A. It's a programme, full exercise programme.
Q. Yeah, oh great. And did you also do activities like pub quiz and bingo?
A. Yeah, bingo's there too.
Q. Yeah?
A. At night time.
Q. Yeah. Did you enjoy that?
A. Oh yeah.
Q. Did you -- yeah?
A. They help us with the counter on a card.
Q. Sorry, what was -- I didn't catch?
A. They put the counters on the card.
Q. Yeah, yeah.
A. I can't do it myself.
Q. Yeah.
A. They put -- I call out "bingo".

Q. Yeah.
A. It was two packets of smokes.
Q. You won two packets of smokes? Nice.
A. I smoked the bloody lot.
Q. I understand you did some physical work while you were there and you mentioned that, can you tell us what that involved?
A. I don't know.
Q. Did you do anything to do with like concreting?
A. Yeah, at school, yeah.
Q. Yeah, at the school?
A. At the footpath, concrete the footpath.
Q. You did concreting of the footpath?
A. Yeah.
Q. Yeah. What --
A. It was on the concrete mixer.
Q. With only concrete --
A. By hand.
Q. Yeah. Was it hard work?
A. The road was bloody hard work.
Q. Yeah?
A. But for the bloody cement, for the concrete.
Q. Yeah?
A. I didn't spill anything out of it. I just take my time to take it over to them.
Q. Did you enjoy that work?
A. Yes, I did. That's something else I do at Tokanui too, tar-sealing.
Q. Yeah?
A. On the road.
Q. Yes?
A. I did that too.
Q. On the roads within Tokanui?
A. In the tar-sealing truck.
Q. Yeah, you worked on that?
A. Yeah.
Q. Yeah?

A. Work on everything.
Q. Yeah.
A. The road works.
Q. Yeah. And you also mentioned earlier that you helped with the mail run?
A. Yeah.
Q. Can you tell us about that?
A. I deliver all the mail to all the wards.
Q. Yeah.
A. And the paper.
Q. Yeah.
A. The Herald.
Q. So was that like a daily job that you did?
A. Yeah.
Q. I think in your statement you talk about that you were lifting some heavy packages?
A. Heavy drug boxes.
Q. Drugs boxes?
A. Yeah, two of them.
Q. Yeah?
A. I put my bloody back out.
Q. Yeah.
A. So bloody heavy.
Q. Yeah.
A. With a lot of drugs in it.
Q. Yeah. Were you delivering them to the wards or something?
A. Yes, I did.
Q. Yeah.
A. And the stationery.
Q. What was that?
A. And the stationery.
Q. Oh yeah, stationery?
A. At the -- the stationery at the – where you get all the medication, the detergent and that.
Q. Yes?
A. I did the stationery there too, do the mail with the stationery on the van.

Q. Was there anything else you wanted to say about the work that you did at Tokanui or I can move on to the next topic?

A. I did a lot of work in Tokanui.

Q. Yeah.

A. Rubbish truck.

Q. Yeah.

A. Put the rubbish on the truck.

Q. Yeah.

A. Laundry truck.

Q. Yes.

A. And the milk truck.

Q. Milk truck?

A. Mmm.

Q. Yeah.

A. There was the bottles – cracking milk around the wards.

Q. Did you have a choice whether to do the work, did you decide yourself or ...

A. I said I wanted to work on the truck, I did on the truck.

Q. Yeah, yeah.

A. I wanted to – --I said to one of the truck drivers –

Q. Yeah.

A. I want a job.

Q. Yeah.

A. How many fullas put the rubbish on the road there, and the milk truck.

Q. Yeah. Peter, is it all right if I move on to the next topic now?

A. Course you can.

Q. Great. I was going to ask you about the next topic which is what we call neglect at Tokanui?

A. Yeah.

Q. So I've got a few questions about that.

A. Yeah.

Q. Yeah. Yeah, did you sometimes go outside of Tokanui for home visits, do you remember?

A. No.

Q. No? Did your parents come and visit you at all?

A. They come to see the staff at -- they want to talk to the staff to take me home, the staff said, "No", not allowed to take me home.

Q. Yeah?

A. "He's happy here with us." Like bloody hell I was.

Q. Yeah?

A. I had all my relations come to see me.

Q. Who was that Peter?

A. My relations.

Q. Your relations?

A. Yeah.

Q. Yeah, they come and visited you?

A. Yeah, down the sports ground.

Q. Oh yeah.

A. With the marching girls.

Q. You had a sister, did she visit you?

A. I went and watched the marching.

Q. Marching?

A. Yeah.

Q. Yeah, outside of Tokanui?

A. In the sports ground.

Q. Squash grounds?

A. Yeah.

Q. Oh yeah. Did you go out of Tokanui to do that?

A. Yeah.

Q. What was the food like?

A. Bloody pig tucker.

Q. Yeah?

A. Yeah, flounder.

Q. Is it fair to say you didn't like the food there?

A. Nah, it's crap.

Q. Were you allowed to have sandwiches?

A. No, we're not allowed, had nothing.

Q. Did you want those?

A. Yes, I do.

Q. Why couldn't you?
A. Doctor bloody won't let me have any of the bloody sandwiches.
Q. Yeah.
A. She's a dietician.
Q. What was the privacy like there, Peter?
A. Not very -- not very private for me.
Q. Yeah, what about at sort of shower time, can you tell us about that?
A. Too many bloody showers around here.
Q. Yeah?
A. I had a bloody fire hose on me all the time.
Q. Yeah?
A. In the shower.
Q. Yeah. Was it cold?
A. Bloody cold, bloody fire hose.
Q. Yeah.
A. Really bloody cold shower, bloody cold fire hose.
Q. Yeah.
A. Inside.
Q. Yeah. How often did that happen?
A. All the bloody time.
Q. Yeah. Every time you needed -- you were having a shower?
A. Yeah. They won't leave me a bloody lone down there.
Q. Won't leave you alone?
A. No. They never treat me properly down there.
Q. Did you ever get sick one time from being outside in the rain?
A. And lying there. I want to go for a walk with someone.
Q. Yeah?
A. But the staff, it was too bloody wet outside.
Q. Yeah. And did you still go for the walk?
A. No, I didn't.
Q. Yeah. Did you go out -- were you out in the rain though?
A. Yeah.
Q. What happened?
A. I got bloody pneumonia.

Q. Pneumonia from that?
A. Yeah. Got put in ward 7.
Q. Yeah?
A. For two, three weeks. I come right then.
Q. So was that -- you got sick from standing out in the rain?
A. Yeah.
Q. Did staff leave you out there or what happened?
A. I stand out there when I was looking for somebody.
Q. Yeah?
A. Yeah, looking for the -- see someone outside.
Q. Yeah. I understand you were a smoker when you were there, do you know when you started that?
A. I started smoking when I was, when I was in Tauranga, Tokanui.
Q. Okay. Were you a boy or...
A. I was a boy, yeah.
Q. Yeah, and did you smoke at Tokanui?
A. Yes, I was.
Q. Yeah. Were you the only one or was it common?
A. I only one smoking.
Q. Okay. Did you receive any therapy for your disabilities when you were at Tokanui?
A. No.
Q. Nothing like that?
A. Nothing like that.
Q. Peter, I was going to ask you now about some of the physical abuse that you suffered at Tokanui?
A. Yeah.
Q. Were you ever verbally abused by staff at Tokanui?
A. Yeah.
Q. Can you tell us about that?
A. They kick me in the bloody stomach they choked me around the bloody neck. Bloody mongrels.
Q. Yeah. Did they say anything to you, any --
A. No, they didn't say nothing.
Q. Yeah, what happened when they grabbed you around the neck, what was --

A. I can't breathe.
Q. Yeah. And who did that?
A. The one in ward 4.
Q. When you were on ward 4, yeah. By a staff member?
A. Yeah, don't know what his bloody name is.
Q. Was there another incident when you were walking to a farm?
A. Yeah.
Q. Can you tell us about that?
A. You know that tree falling down?
Q. Mmm?
A. I walk on that, they kicked me in the knee -- kicked me in the stomach with a knee cap.
Q. Who was that person?
A. Staff nurse.
Q. Yeah.
A. He's a bloody mongrel.
Q. Yeah.
A. I never liked the bugger either.
Q. So he kicked you?
A. In the stomach with a knee cap.
Q. And what happened?
A. He threw me to the bloody ground.
Q. Yeah?
A. In the blackberry bush. I stayed down there too.
Q. Yeah. Were you injured from that?
A. No.
Q. Yeah? Were there any times, other times you were, like, physically assaulted by staff?
A. Yes, I was.
Q. Can you tell us anymore about that?
A. He bloody assaulted me all the bloody time, he did.
Q. That same staff nurse?
A. Yeah, the both of them.
Q. Yeah. Was it mainly two staff members?
A. Yeah.
Q. Yeah. Were you ever threatened by the staff members?

A. No, I threatened them. I'll give you a good bloody smack in the bloody mouth he gone lose a tooth.

Q. You fought back sometimes?

A. Yeah.

Q. Yeah. Did any of the staff ever strike you, like punch you?

A. No, only – [GRO-B] – punched me in the eye.

Q. Who was that person, was he a staff member?

A. He's a staff member.

Q. Why did he punch you in the eye?

A. I don't know.

Q. Yeah.

A. He just felt like it.

Q. Yeah. Were you on the ward or...

A. Yeah, I was on the ward there.

Q. Yeah. So just out of the blue he punched you?

A. Yeah. I didn't say anything to them, to him.

Q. Yeah.

A. "Hey [GRO-B] what are you doing, come over and I'll punch you in the bloody eye."

Q. Yeah?

A. "You want a smack in the mouth?"

Q. Yeah.

A. "You try it."

Q. Yeah?

A. "I try it on you too. Smack you in the bloody eye, you dead black in the eye."

Q. Yeah.

A. That's what he said to me. I said, "Like hell you'll hit me in the eye."

Q. Did he say anything when you asked him why he punched you?

A. No, he didn't say nothing.

Q. Yeah. Did any other staff see it?

A. No, only him.

Q. Okay.

A. Only that mongrel did.

Q. Yeah. Did you ever get punched or assaulted by any other patients?

A. I had a lot of bloody hidings from them, the whole bloody lot of them.
Q. Yeah?
A. Gave me a bloody hiding. They want to call me Black Power behind my back.
Q. Yeah?
A. Yeah, the bloody buggers.
Q. They said you were Black Power?
A. Yeah, I had a jacket on.
Q. Oh yeah?
A. A black leather jacket.
Q. Yeah?
A. Leather jacket.
Q. Yeah.
A. With a patch on the back.
Q. Yeah?
A. It's not my jacket, it was [GRO-B] jacket.
Q. Yeah?
A. He let me borrow it.
Q. I see.
A. I gave it back to him.
Q. Yes.
A. I said to that fellow, walk across the -- walking across the – walking across –
Q. Yes.
A. – to the hall, "Hey Black Power", "say that to my face and I'll smack you one." Bloody mongrel.
Q. What would happen if you complained about any of this?
A. I'd give them a bloody hiding, I will be. I'll fix the buggers.
Q. Yeah.
A. Don't you worry about that.
Q. Would the staff do anything if you told them that you were being assaulted?
A. Yes, I did.
Q. Yeah.
A. He didn't take any bloody notice, he never take any notice of me.
Q. Yeah. And so nothing happened?

A. No.
Q. What about, did you tell anyone else, like the Police?
A. I told two Police, I told two cops in the paddy wagon.
Q. Yeah?
A. In the Police wagon, "I've been assaulted, I've been kicked in the guts, been choked around the neck, and do something about that."
Q. And what, did they say anything to you?
A. No.
Q. Nothing, yeah. They didn't do anything that you're aware of?
A. No.
Q. I was going to ask you now, Peter, about sexual abuse that you suffered while you were there?
A. Yeah.
Q. Yeah. Can you tell us about that?
A. [GRO-B] he tried to have a fuck and have sex with me.
Q. Yeah.
A. In the bloody bathroom.
Q. Yeah. He was another patient, is that right?
A. Yeah.
Q. Yeah. And if you can talk about it, yeah, what happened, or what happened when he tried to do that?
A. I said, "Get off me you dirty bugger."
Q. Yeah.
A. He won't listen, he keep on doing it.
Q. Yeah. And did it, yeah, did it stop or like what happened?
A. He stopped.
Q. Yeah.
A. I went and looked around, and smack him in the bloody mouth.
Q. Yeah?
A. “Take that you dirty bastard.”
Q. Yeah.
A. "You do that to me again, I'll kill you next time."
Q. And did he try and do it again?

A. Nah.
Q. Yeah, so it was just that one time?
A. Yes, just that one time, yeah.
Q. Did he threaten you?
A. Who? No, he didn't threaten me at all.
Q. Okay.
A. He never touched me at all.
Q. Yeah. Did you feel you could tell anyone about what happened with that?
A. I told the Police about him.
Q. Yeah?
A. The Police said to him --"[GRO-B], come with me, I'll put you in the paddy wagon."
Q. Yeah?
A. "I'll put you in jail."
Q. Yeah. Do you know if that happened or not?
A. Nah.
Q. It didn't happen?
A. Nah.
Q. Is there anything else you wanted to say about that, Peter, or we can move to the next topic?
A. Move to the next one.
Q. Yeah. So the next thing I was going to ask about was the medication or the drugs?
A. Yeah, the bloody -- make me bloody sleepy.
Q. Yeah?
A. Yeah.
Q. How often were you given medication there?
A. All the bloody time.
Q. Every day?
A. Yeah.
Q. And yeah, what -- do you remember any of the names of the medication?
A. It was Largactil.
Q. Yeah?
A. A syrup.
Q. Yes?
A. An injection.
Q. Injection? You mentioned that it made you tired or sleepy, is that right?

A. Yeah.
Q. Were there any other effects of the medication?
A. Nah.
Q. How long did that tiredness last?
A. I don't know.
Q. Do you know why you were getting the medication?
A. It's the bloody doctor's idea.
Q. Yeah. Could you say no to it or not?
A. I said, "No, I don't want the fucking -- I don't want that bloody crap."
Q. Yeah?
A. He never bloody listened to me.
Q. But you still got it?
A. Yeah.
Q. Did they explain why you were getting it?
A. No, they never explained anything.
Q. Did you ever receive shock treatment at Tokanui?
A. They never get me on this machine, they never give me any shock treatment.
Q. Yeah.
A. The other fullas did.
Q. Yeah.
A. A lot of the patients had shock treatment, not me.
Q. Yeah.
A. I got away from it.
Q. Okay.
A. They never find me anyway.
Q. Yeah?
A. Ha ha ha.
Q. Yeah. Was there anything else you wanted to mention about the drugs, Peter, or shall we go on to the next?
A. Go on to the next one.
Q. Okay. You've told us in your statement about a drowning incident that you witnessed at Tokanui?
A. Yeah, one of the girls got drowned in the pool.
Q. Yeah.

A. I got her out there, I was out -- I was in there with my togs on.
Q. Yes?
A. I got her out, gave her mouth-to-mouth.
Q. Yes?
A. She never came back to life.
Q. Was she a young girl?
A. Yeah, she was young.
Q. Was that at the swimming pool at Tokanui?
A. Yes, nobody was watching her.
Q. No-one was watching her?
A. No.
Q. What about, were there staff members around?
A. The staff members up on the top of the bank.
Q. Yeah?
A. Talking to someone.
Q. Yeah.
A. He didn't take any bloody notice.
Q. Yeah. Did the staff see that she was in trouble or were they too busy?
A. They're too bloody busy.
Q. Yeah.
A. I said, "You lazy pack of bastards don't do nothing around here. You don't want to help her -- help her when she's drowned."
Q. Yeah.
A. I got her out myself.
Q. Were you swimming at the time as well?
A. Yes, I was.
Q. How did you feel when she passed away?
A. I was really upset.
Q. Yeah.
A. I wasn't crying though.
Q. Yeah.
A. I was really angry.
Q. Yeah.
A. That girl's gone, she's gone, that's all it is. They can't do anything about it.

Q. Yeah.
A. I just stayed there with her until the oxygen bottle comes, the gas bottle.
Q. Yeah.
A. Keep her alive.
Q. Yeah.
A. She never make it.
Q. Yeah.
A. I wait there until the undertaker comes.
Q. Yes.
A. For the body.
Q. Yeah.
A. I say goodbye to her.
Q. Did the Police ever come?
A. No, they're too busy with the prisoners. Was one prisoner in the van. I had a Police shirt on too, I was, and a gun on the side.
Q. Okay.
A. They want me -- the two cops said to me in the Police van, in the Police van, " You want a job?" I said, "Yeah." "Hop in the back with the prisoners, look after them, keep them from escape."
Q. Yeah?
A. I'm on my own too with him, with the prisoner.
Q. Yeah?
A. "You escape or I'll bloody kill you. I will."
Q. Was that -- with the Police, Peter, was that separate to the drowning incident, or...
A. No, [inaudible], no, not drowning.
Q. No, it's a different thing?
A. Yeah.
Q. Yeah. What happened with the young girl that drowned, what happened to her, was she buried?
A. Yeah, she's buried in the cemetery.
Q. Yeah, at Tokanui?
A. Yeah.
Q. Yeah. Did they have a funeral?
A. No.

Q. Did you see her get buried or you just know that she was?
A. I was there when she got buried.
Q. Yeah.
A. I said goodbye to her.
Q. Yeah.
A. Rest in peace.
Q. Yeah. Is there anything else about that that you wanted to say?
A. That's all.
Q. Yeah. Peter, I was going to just ask you about how did you get out of Tokanui in the end?
A. I talked to the superintendent and the social worker.
Q. Yeah?
A. Got me out of there.
Q. Yeah. Were you about -- were you around age 24, does that sound about right when you got out?
A. Yeah.
Q. And where did you go from there?
A. To Tauranga. I got out of there as well. That place no good for me down there.
Q. How did you feel when you got out of Tokanui?
A. Happy like anything. You're not going to come near me again.
Q. Yeah.
A. Get away you bloody mongrels. I didn't say goodbye to them either. They can go to hell. And I say to them.
Q. So you were definitely happy to get out of there?
A. Yeah.
Q. Did you go to a hostel in Tauranga?
A. Yes, I was.
Q. Run by IDEA Services?
A. Yes, I was.
Q. What was that like?
A. The hostel?
Q. Yeah.
A. Good.
Q. Yeah. And there were others living there at the same time as you?
A. Yeah.

Q. Yeah. And you liked it there?
A. Yeah.
Q. Yeah.
A. Get on with the manager.
Q. I just want to ask you briefly, Peter, what sort of like long-term impact has Tokanui had on you, on your life?
A. I don't know.
Q. Yeah. Do you think it's had a positive impact or a negative impact?
A. Negative.
Q. If you look back on your time there, do you think -- what do you think about it?
A. Bloody pack of bloody rubbish.
Q. Yeah.
A. Burn the bloody thing down, set it on fire. Burn the whole bloody lot.
Q. And what about now, how do you feel about it now that you're out of there?
A. I feel happy now.
Q. Yeah?
A. I got out of there.
Q. And what about -- have you ever received anything, we call it redress or compensation from the Government or anybody for your time there?
A. No.
Q. Is there anything you'd like to see happen about Tokanui?
A. Bloody burn the bloody thing and get rid of it.
Q. You're now living in this rest home here in [GRO-B] in Whangārei, how do you - what's- it like here for you?
A. Here?
Q. Yeah.
A. Good.
Q. Yeah?
A. I like it here.
Q. Yeah?
A. All my friends, all my neighbours here.
Q. Yeah. That's good. And what about the staff here, do you like the staff?
A. I like all the staff here.

Q. Oh good. How does it compare to your time at Tokanui?
A. Terrible down there.
Q. Yeah. And you feel that you're well cared for here?
A. Yeah.
Q. Yeah. That's about -- that brings me I think to the end of my questions, Peter. Is there anything you wanted to say?
A. No.
Q. Anything else?
A. No.
Q. Yeah. Thank you so much for your time and for giving your evidence on the recording today.
A. That's all right, you're welcome".
MR THOMAS: Peter, it's Michael here, can you hear me?
A. Yeah.
Q. I just wanted to -- what did you think of that?
A. Yeah.
Q. I just wanted to thank you for giving your evidence and I think you did a great job.
A. Thank you very much.
Q. No, thank you. I'll leave it over to the Commissioners to thank you as well, but I hope to see you again in the future.
A. Okay then.
Q. Thanks Peter.
A. Thank you too.
COMMISSIONER STEENSON: Hello Peter, I'm Julia, one of the Commissioners. It's nice to meet you.
A. How are you?
Q. I'm good thank you. It's been so important for us to hear you speak about your life today, Peter, thank you so much. You've helped us understand what it was --
A. Thank you very much too.
Q. Yeah, you've helped us understand what it was like for you being at Tokanui for 20 years from the age of five?
A. Yeah, the fuck'n murderers down there.
Q. Mmm, how it was like a prison and all the things that happened there.
A. Prisoner, the fuck'n murderers down there.

Q. I want to say that I absolutely admire you for your strength, Peter.

A. Yeah.

Q. Admire you.

A. I'm glad I got out of there.

Q. And I wish you all the best.

A. Bloody [Inaudible].

Q. I wish you all the best, I'm glad that you're in a place you're happy now and on behalf of the Commission --

A. Yeah.

Q. -- thank you so much.

A. Yeah, that's all right, thank you.

Q. Thank you, take care, bye-bye.

A. Thank you so much.

CHAIR: Goodbye Peter. We'll take a break now. How long would you like?

MR THOMAS: Thanks Madam Chair. If we could come back at, shall we take 15 minutes?

CHAIR: Come back at quarter past 3?

MR THOMAS: Thank you.

CHAIR: All right, thank you.

Adjournment from 3.02 pm to 3.20 pm

CHAIR: The last session of the afternoon, good afternoon. Mr Thomas.

MR THOMAS: Thank you, Madam Chair. The next witness is Caroline Arrell, and she is obviously here in person.

CHAIR: Yes.

MR THOMAS: She'll be talking about her time as a training officer in the psychopaedic side of Tokanui Hospital and also her involvement in the closure of Kimberley later in her career. Caroline is very happy to take questions during her evidence.

CHAIR: Thank you. I'll just ask you to take the affirmation.

CAROLINE ALICE ARRELL (Affirmed)

QUESTIONING BY MR THOMAS: Caroline, can you start off by just telling us a bit about your training and professional background?

A. Sure. Kia ora mai, Caroline Alice Arrell. I've had a 35-year history of working in the disability sector as Michael said, starting off as a young training officer at the age of 18 at Tokanui Hospital.

I then graduated after three years of completing my psychopaedic training officer diploma to become a tutor training officer, spending probably eight to nine years in Tokanui during that time.

I then moved on to work for the Waikato Community Living Trust as a case manager for the de-inst [deinstitutionalisation] process of Tokanui Hospital, and I had a caseload of around 120 people that I repatriated to their chosen domiciles.

When Tokanui closed I was fortunate enough to join the pilot project of the very first NASC in New Zealand – that's Needs Assessment and Service Coordination Agency – called Accessibility in Taranaki, where I worked from Hawera.

I was then asked to join the IHC as a national trainer, with my background in teaching, which I took on and did that for a couple of years. And then moved to be the team leader for the behaviour support services in IHC for the central and southern regions. And had a team of about eight people and responsible for around 600 people that were referred to us.

After that I then was the project manager for -- from 2000 to 2007 I was the project manager for NZ Care in the deinstitutionalisation of Kimberley Hospital. I was responsible for 312 people from Kimberley who were being resettled back into their, or their families', chosen domiciles. I was responsible for the purpose building of the cluster housing models and the individualised housing models. I'll talk more about that in my evidence.

When that finished I needed to take a year off and have a break, and then I rejoined IHC as the national manager of self-advocacy for three years.

And then since then I've had two roles, one as a service manager with NZ Care, and then latterly area manager for NZ Care for the Greater Wellington area.

But for the last two years I've been travelling New Zealand looking for our piece of dirt, which we have found in Taupō, so that's where I reside now.

Q. Thank you for that, Caroline.

Did you want to make some opening comment about why you're here to give evidence?

A. Yeah, sure. I understand that my evidence augments and supplements the stories already told by people who have disabilities. Through the lens of their own experience they have been able to describe abuse and neglect in institutions or they've had very powerful advocates to tell those stories on their behalf, such as Margaret, kia kaha Irene.

But today my stories revolve around people who had no family involvement, who had a receptive understanding of the world around them, but could not express in any way

using formalised language or any other type of language to convey, communicate the terror, the trauma, the abuse and neglect that they endured at Tokanui and Kimberley Hospital, so perhaps the most vulnerable of vulnerable in my mind. So again, thank you for the opportunity to do this.

Q. Thank you. Caroline, can I just get you to start, you mentioned you started at Tokanui as an 18--year-old- in the training centre. Can you just give the -- everyone an idea about what that training centre was like, how many children attended, just the set-up of that?

A. Sure. The training centre, as you've heard from other evidence -- well, actually, the training centre at Tokanui was probably one of the newest training centres at that time, it was purpose-built, so it was a building that housed about eight classrooms, and predominantly drew children from the village part of the -- so Tokanui was three hospitals, so it was Te Mawhai Hospital for the elderly, then there was a psychiatric side of the hospital, and then there was the Waipā Community and Training Centre which was dedicated to children and young adults who had intellectual disability.

So when I arrived at Tokanui, there was around about 3 to 400 children in the Waipā Community and Training Centre, of which approximately 42 came to the children's training centre. And the classrooms were designed as classroom sizes of four to five pupils per classroom with one training officer. Unlike Māngere, we did not have psychopaedic nurses in our classrooms. We were autonomous and overseen by clinical psychologists and/or senior training officers.

Q. Thank you. You mention the children's village and in your written statement there's also discussion of the other general wards so, just to clarify, would both children and adults from different wards in Tokanui attend the training centre?

A. Yes, some did. So there was probably eight to nine wards within the Waipā Community and Training Centre plus the children's -- plus, sorry, the village complex. So yes, we did draw from other wards people who came to the training centre, yes.

Q. Were most of the attendees at the training centre from the village, or were they drawn more widely?

A. Yes, most of them came from the village. Perhaps, you know, four or five young people from ward 19, 16 and 17, yes.

Q. And by -- when we're talking about the children's village, that was a specific area within Tokanui?

A. Yes, it was, it was deemed -- it was -- they were a cluster of houses that look like, I liken them to State houses, so they were in a circle in the middle of the Waipā Community and

Training Centre, and they were four- to five-bed houses that were meant to resemble more home-like living. So each of the children that lived there -- and so these children were between probably four and 18, so it was meant to resemble more of a family hom e-like environment. So each of the children had their own rooms, although some of them did share, from memory, as well, yeah.

Q. Thank you. Can you tell us more about how children came to be at the training centre?

A. There was a selection process around, the children that lived at the -- in the village complex – were deemed to be more cognitively able, that they would be able to be educable in some way, that they had the ability to learn new skills and they were independently ambulant, so they walked over to the children's training centre each day or they rode tricycles or rode on scooters, but mainly walked over.

Q. Were families encouraged to place their disabled children at Tokanui?

A. Well, initially as a young 18-year-old I wasn't privy to that information, but latterly when I joined the case management team with the Waikato Community Living Trust, I learned of their stories around why they placed their child into Tokanui Hospital. So, you know, like the stories you've heard, they were advised to place their young family member into care and to basically get on with their own lives.

For some of the families they didn't have the support structures back then that enabled them to keep their disabled child at home. For some of the mums they were on their own, and they couldn't cope. So there was no services available at that time for them to be able to do that. So that was a common theme of stories.

I also need to add that also in the Waikato Community Living Centre there was a ward where babies were, so young children that had been admitted as babies and who had no family contact whatsoever.

Q. Your role as a training officer, can you just give us a bit more of an idea of what that involved on a daily basis?

A. So each child was -- that came, was assessed on skill acquisition, what would support them to live a more functional life, I suppose. Although, in reflecting back on it, I often wonder how helpful that skill acquisition was. We taught things like money recognition, reading, writing, spatial awareness, how to have a conversation, interactive techniques, yeah. And adaptive behaviour, so daily activities -- sorry, activities of daily living such as how to cook, how to dress for the weather, how to colour-coordinate clothes, how to make their own bed. Again, all in a classroom setting which I'll talk about a bit later about how we've kind of changed that.

Q. Thank you. I just want to talk about briefly the different teaching techniques or theory that you used at the time at the training centre. Are you able to explain that?

A. Yeah, sure. So this is in 1979 through to 1982, I believe. When I arrived, we employed teaching techniques from an applied behavioural analysis model, very stringent teaching practices that were based on a series -- based on the theory that behaviour and learning could take place through the process of rewards and consequences.

It was an extremely sterile and stark form of teaching. It was devoid of any love or compassion and I can describe it as extremely clinical.

Q. Could you give us an example of, say, a positive reinforcement technique or some other example of that?

A. So I'll give you a concrete example of actually a teaching session. A child would sit opposite me and it looked like a regular classroom, and I would teach them money recognition. So I would have the money out on the table and I'd ask them to identify which was the $5 note. If they got that correct they would get a teaspoon of yoghurt, as an example of positive reinforcement. Edible reinforcement was predominantly used as positive reinforcement. And, again, later in my testimony I raise ethical questions about that.

So that was reward token systems, and verbal praise, yeah.

Q. Thank you. You also mention other techniques involving, you describe it as positive punishment, or that's the term you use?

A. It's incongruent, isn't it, positive punishment? For a lot of the children in the trial -by-trial teaching, in fact in any teaching situation, if they got a response wrong, say I'd ask them to identify or point to or show me the $5 bill and they pointed to the $1 bill, there was a technique employed, I suppose you could say an aversive consequence in the guise of positive punishment, where I would say "no" to the child, take them by their elbow and walk them to the purpose-built in-built -- so the training centre was designed to have time-out rooms in every single classroom. They weren't wooden boxes as described from Māngere, but they were purpose-built. They looked like closets, they had four walls, no windows, and they had doors that locked from the outside. So the child -- but they had a light switch that was left on. And they were escorted to the time -out room and they were left in there for three minutes with one minute of silence and then they were brought out and expected to resume a teaching session. Yeah.

I'm sorry to describe this to you like this, that's what it was. It was an expectation of our training that if we didn't comply with those techniques, then we wouldn't have a job.

So this was a common theme and common practice across most of the training centres within Templeton, Māngere, Tokanui and Kimberley.

So yeah, that's one of the --

Q. Thank you -- sorry.

A. -- positive punishment.

Q. Thank you. Looking back or reflecting back on those techniques now, what do you think about them?

A. I think they were absolutely abhorrent. In fact, on one occasion I was asked -- a little boy, he must have been four years of age, and I'll call him "T", and I was asked to conduct this process with him during a session of clothing recognition and I refused. He was four years old, you know, this was just an abhorrent process. And one -- it never sat well with any of us this practice. But, I think as Olive described earlier in her evidence, it was just the time, it was what we had to do, it was expected of us. And, again, if we wanted to see our qualification through we had to comply.

Q. You mention in your statement the use of ammonia capsules at other psychopaedic hospitals. Do you want to discuss that?

A. Well, we never -- that was never employed at Tokanui, I never, ever saw that used. I actually think that that would have been a bridge way too far for any of us to consider. That was -- but I do know from a colleague at Kimberley that it was used, without success, on a young woman there as prescribed by a consultant psychiatrist that was visiting Kimberley.

Q. Caroline, can you tell us about what other forms of punishment were used at Tokanui?

A. Punishment was pervasive, it permeated daily life for all the young people that I got to meet and know and work alongside. I was indignant that the -- in-classroom style of teaching, whilst important, I wanted to go and teach skills to these young children at the right times of the day. So if I was teaching them, for example, to get dressed or recognise the weather, I would go to the ward, or I would go to the villa and I would teach them at that time.

So I got to see punishment from two contexts, I got to see, you know, our clinical teaching punishment, which I've described to you, and I also got to see punishment, well, clearly intertwined with abuse on the wards.

Withdrawal of privileges -- we're going to go on to talk about some of that a bit later, aren't we? So punishment --

Q. We will, yes. I was thinking about paragraph 2.16 of your statement where you discuss food and water being used as a form of punishment. Do you want to mentio n that?

A. Yes. So, I mean, the withdrawal of -- for non-compliance of behaviour, not getting ready in time to come to school, breakfast being withdrawn, social isolation, the punishment of threatening to tell families about behaviour, meaning that they would have to live longer within the complex. Having food withheld, again, without talking about all the indictments of what I witnessed in terms of abuse, that was some of the things in relation to my teaching time on the wards.

Q. What about communication being used as a punishment?

A. So...

Q. In the sense of not being allowed to communicate with family, was that used?

A. Yes, it was. So for any misdemeanours, I mean, these children lived in very regimented and rigid, you know, routines and timetables, and any misdemeanour against that was met with punishment such as no phone calls to their families, not being able to see their friends, having privileges to go out on picnics or outside of the hospital taken away from them, yes.

Q. You wanted to mention a specific incident that you witnessed of electric convulsive therapy at Tokanui, do you want to describe that?

A. There was a young woman that I worked with who was described and diagnosed at 10 years of age of having a type of schizophrenic melancholy, she was very taciturn, didn't have a great attention span, according to the paediatrician that worked on site. These days she would clearly sit on the autism spectrum. That would clearly be her diagnosis.

Now, I can't tell you if her parents were asked for consent or permission, but I supported her on three occasions to go down to this very small unit next door to the admin building at the entrance to Tokanui Hospital to have ECT [electro-convulsive therapy]. It was one of the most traumatising experiences I have ever had in my life and I have no idea how K survived this. She was taken into this small room and strapped fully clothed on the bed and, to me – and I could be quite mistaken with this – it was a technician who administered ECT.

The reason I say that is because sometimes we would see him around the wards acting as an electrician so, you know, I don't know what his qualifications were. There was a psychopaedic nurse in attendance and myself, and K had ECT administered to her twice on each occasion.

Q. How old was she?

A. 10. She was 10.

Q. Was she sedated?

A. Yes, she was sedated, she was sedated. And after she had ECT she was -- I would just describe her as like a zombie. She was in my classroom, I was responsible for her during the days and after ECT she would come over to the classroom and we would forgo all teaching. We would build a bed in the room, we would sing, tell stories, we would completely ignore the teaching plan and I would falsify teaching records so that she could have, just that time to relax and try to understand the world around her after that dreadful experience.

I also want to add to that that for the other people, the other young students in the classroom -- now, I had these same students for four years and we formed a very close bond. They also were very distressed at seeing K like this, and so we would -- which was interesting because four of these young people couldn't communicate using expressive language but they clearly understood what had happened for K and they, like me, were remorseful, sad and just wanting to take good care of her.

Q. Can I move on to talk about environmental abuse or neglect at Tokanui. There's a number of aspects of this in your statement, starting with – what about smoking in the environment?

A. So, as I said earlier, I was able to not only work at the training centre but I got to go teach skills such as bathing, eating, exercise, within the wards. Back then everyone smoked, all the staff smoked, and the wards were full of smoke, there was ashtrays everywhere. So people with disabilities that lived in these wards were subject to the inhalation of smoke all day. It was nothing to see four or five staff in a day room smoking and it was full of smoke, and I often wondered, you know, the impact that that had on the young bodies.

Gosh, environmental abuse. It was -- as other people have described, it was devoid of any activities, devoid of anything meaningful to do. I'm just going to look down at my ...

Q. Sure.

A. Oh, yes, so the TV; TVs were in every ward and in most rooms and were turned up very loud. They were TVs that were behind glass panels pinned on the wall with no remote, so it was always -- the staff had control of the remote, so it was always set to programmes that they wanted to watch and it was loud. For me, the neglect and abuse around that was that people never had any peace or quiet or -- so staff would play music of their own liking, often reggae music, loud, so there was always a lot of noise, it was incredibly destructive for the well-being of people having to endure all day in those day rooms.

Q. Several times in your written statement you talk about this theme of teaching relationships being transactional rather than relational. I was just wondering if you could explain that for the Commissioners, what you mean by that?

A. Well, in all relationships that I witnessed in both Tokanui and Kimberley, it was all based on getting people up in the morning, getting them fed, getting them showered, all happening before 10 am so they had nothing else to do for the rest of the day. Transactional was "just what I have to do", conversations were never relational. In fact, I give examples in my testimony of showering and eating. Two things that should be incredibly pleasurable for young people to have and instead they were extremely devoid of any type of good interaction.

I'll give you a quick example. The bathrooms and the showers -- now, I was there teaching a young boy in the bathroom to -- how to bath himself. How to get undressed, how to turn the taps on, how to check the temperature, hop into the bath. So I was able to witness the bathing schedule of the other four to five baths that had no covering or privacy, and so what happened was, is that they were stripped off and they were bathed on type of a conveyor belt -- it wasn't a conveyor belt, but there was a staff member that put them in the bath, another staff member lifted them out, dried them, then another staff member dressed, all while the staff were talking amongst themselves, never to the child or never to the person that was receiving their support. So that's what I mean by transactional, it was a very transactional approach. I saw that in many interactions.

In fact, I use that term a lot, transactional rather than relational.

Q. Thanks for explaining that. Can you tell us about over-crowding and clustering in the wards?

A. Within the Waipā Community and Training Centre, like Tokanui Hospital, the wards seemed to be designed on kind of a thematic style. So, for example -- can I use the name of wards?

Q. Yes.

A. So, for example, ward 16 was for people who used wheelchairs for their mobility, they had no ability to move any part of their body, very few of them were able to speak. Now -- and then there were other wards for young people who had more problematic or, as is described, challenging behaviour.

What this meant was, especially for people who couldn't speak or who used specialised seating and wheelchairs for mobility was they had no ability to converse with each other. It was -- they were clustered for ease of the working conditions for the staff so...

There was another ward that had men who were described as being -- maybe there was 32, 33 young men in this ward who were described as having challenging or aggressive

behaviour, and a fairly set staff roster in each of those wards. So in my evidence I describe that caring for or supporting 32 men who have these types of behavioural repertoires added to the stress, I suppose, or the lackadaisical approach of the staff, looking after them.

I think, though, if I can just go to people who were more dependent, there was an absolute void of conversation or interaction with these young people in those wards. It was: Get them up, get them dressed, give them their food which was a whole other place and activity that I found extremely distressing, and I made a point of getting permission to work in ward 16 to teach a young man how to scoop his food up with his spoon.

The abuse that I saw during eating was that the food arrived, as you know, on a tractor and it was brought in in these large wheeled heated ovens and the food was spooned out, never tasted first, which is something that I want to talk about, and it was all placed into one plate and then stirred up. It resembled a cow pat pie, which is what we -- it's what, yeah, that's exactly what it looked like, it looked like a cow pat pie. And people were given their food incredibly fast. They used -- they didn't use specialised spoons and everyone had a plastic bib around them that had a catchment area at the bottom. So for the food that didn't go into their mouths and dribbled out into the plastic bib, it was re-spooned up from that plastic bib back into their mouth.

Now, it was cold, it was abhorrent, I spent a lot of time trying to advocate for the change in this, but it was purely based on convenience to get food quickly into people.

I'd also like to add that for many of the people who needed full support to eat, they were extremely thin, extremely thin and underweight.

It took, especially for people who had cerebral palsy, a long time to form a bolus and swallow. Same for drinking. It takes a long time to take a sip, get organised in your own mouth to swallow it, and they were fed extremely fast. So, consequently, a lot of food didn't make it down.

Now, for me, that was a neglectful and abusive practice. The other part of that, and I come back to tasting, no-one ever tasted the food that came in. So when I was working on this particular ward, I would make a point of going and tasting it and I soon realised why it was so abhorrent for people to swallow, it was often over salted, and it -- some of it was inedible.

So whilst there were dieticians, the food across all the wards and villas that I saw was the same.

CHAIR: Can I just ask you, was the food all pureed up?

A. Yes.

Q. All the food for everybody?

A. Yes.

Q. Goodness.

A. In this particular ward, yes.

Q. Oh, in that particular ward?

A. Yes, yes. So in the village clearly no.

Q. Right.

A. Because they could -- it didn't need to be, they could chew, they could masticate.

Q. But in that particular ward all the food was mushed together?

A. Yes. Look, in saying that also I have to say that in other wards, in another ward, particularly, there were people there who could actually support themselves to eat, but they were not given that opportunity.

Q. Right.

A. And the food was mixed up. For people with disabilities, if they were reluctant to eat the food like that, their arms were restrained to the chairs that they were sitting in, and they were basically -- I would describe it as being forced to eat.

If the process became too hard for the staff, then they would be verbally abusive and say, "Well, you had your chance to eat it, too late now, you know, you're not going to get it." So that was quite common.

QUESTIONING BY MR THOMAS CONTINUED: Caroline, you mentioned that there were -- you tried to change the eating practices. Can you briefly describe how you went about that.

A. So I was often accused of having rose-coloured spectacles, and I suppose I did to a degree because I felt that I could go and role model good practice and -- but clearly that was met with resistance and attitudinal barriers from the staff. Basically they described me as being a bit of a Pollyanna and that it took too long, it took too long to serve the food in individual piles to let them taste the potatoes, to let them taste the broccoli, you know, to give them -- what does pumpkin taste like, to establish those individual and personal preferences, that was just way too hard.

I had very little impact on that. Yeah, for me meal times and bath times were extremely distressing experiences and I never got used to seeing that or experiencing that. So what I did, I guess I tried to be a good role model, I tried to talk to the charge nurse about, you know, what it must be like to have that experience.

One success we did have, though, was during my time as tutor training officer I got to teach a course called Effective Teaching and people from other organisations would come from outside of Tokanui to come and learn these modularised packages of learning. It was how to teach people with disabilities.

One of the activities that we did was we would restrain the participants in a chair and give them their food like I had seen it being given. I know that sounds dreadful, but it was actually a very cathartic experience for those participants because they realised how transactional and abusive the process actually was.

But I had very limited success in my advocacy for any change of eating practices within Tokanui.

Q. Moving on to another topic, did residents physically hurt and assault each other at Tokanui, can you talk about that?

A. Yes, along with self-injurious behaviour which was prevalent, I mean, I'm sure we would all engage in self-injurious behaviour if we were living in those conditions, but yes --

Q. You talk about -- oh, sorry.

A. No, no, well, there were very vulnerable people who couldn't defend themselves living with others who were described as having challenging repertoires or aggressive repertoires of behaviour and they would hit out at the more vulnerable people or bite or kick or scratch.

So, to me, I likened it to living in an extreme domestic violence situation. It was never incident reported. There were some very serious injuries inflicted, particularly on one young man I remember, and I'll call him R, he couldn't move any part of his body, he was a very young boy of about 10 and he got bitten so severely that it drew a big chunk out of his arm.

So I asked what was going to happen next to minimise this happening? Again, there was no overt process for keeping people safe. It was never incident reported and that's something that, you know, I'd like to also focus on when you look at contemporary service provision today, is how incident reports are generated around this. But this was a very big issue, self-injurious behaviour and other accidents and injuries and incidents involving peers on peers, yeah.

Q. What about sexual abuse at Tokanui, was that something you were aware of?

A. Yes, it was reported to me in a friendship that I had with a young man who I worked with, and I'm going to get to discuss him --

Q. Yeah, we'll come to that specific case in more detail, but I guess outside of that specific case, were you aware of any, yeah, sexual abuse occurrences?

A. Clearly it was reported to me by people who -- with disabilities, but it was never believed and it was never investigated. And when they would give me this information I would have to pass it on to the charge nurse or I would have to relay it to others and nothing was ever, ever done about that, to my knowledge. And I was always clear about following that up, what had happened.

Q. Okay.

A. "Oh, they just talk about being abused all the time, it never happens, they say that so-and-so has sexually abused them, but that's just them, they say that, it's not true." So it was never believed.

Q. You wanted to talk about toileting practices at Tokanui, can you give some examples of that?

A. Toilet paper. Again, it reminded me that in most of the wards there was no access to toilet paper. So as described by others, the -- toileting was a very public affair, there was no privacy. In one particular ward people were strapped and restrained on potties until they had passed bowel motions. That could be up to 45 minutes.

The way in which people were cleansed was rough, and it was without -- it was devoid of any respect or dignity. In fact, often people were taken off the toilet, particularly people who could not walk but they could crawl, they were lifted off the toilet and left to crawl away from the toilet while the staff member was wiping their backside, yeah.

So it was devoid of any privacy and it was -- yeah, that's all I'll say about that.

Q. What -- was dental care available for children at Tokanui, or residents, actually?

A. We had a dentist at Tokanui and he was described as a rough and unpleasant man, and no-one ever wanted to go and see him. Dental care was not proactive, it was only just needed as recognised. So often teeth had to be quite in a bad state of repair before they would go to the dentist and often that response was to whip one or two out.

One of the worst, I suppose -- well, it was all incredibly confronting, but particularly for one young man who was described as a biter, he had his teeth removed, all of his teeth removed for biting others, with no meaningful look at why he was biting, what led to this.

The dentist was an incredibly unpleasant place to go. Often sedation was required for the children and the young people to go to the dentist. And if anything more serious was needed, they were taken to Palmerston -- sorry, they were taken to Waikato Hospital, Palmerston for Kimberley, to be seen under general anaesthetic.

Q. Thank you. You talk about the lack of respect for people's sexuality at Tokanui. Do you want to mention that, or give any examples?

A. People were described as being asexual. There was no acknowledgment around puberty, around young people's needs. There was no teaching around masturbation and privacy. People were taunted about their bodily functions, I suppose.

Q. Taunted by staff?

A. Yes, taunted by staff. So there was a gentleman who had nowhere to go, he was -- he had no privacy and he would get erections and he would masturbate in the day room and the staff, and I witnessed this on many occasions, would stand around and taunt him and laugh and describe that the size of his appendage was wasted on him.

There were many young people whose body parts were openly discussed, especially during the shower process, discussion around the shape of their genitals, discussion around the shape of their breasts, and taunted about this.

Staff would show a level of revulsion about having to cleanse people's intimate parts and would say that quite loudly while they were showering the woman or the man.

Q. Thank you. I'm going to jump ahead to another topic now, I just wanted you to summarise this topic, if you can. You discovered an unmarked graveyard at Tokanui. Can you tell us how that came about?

A. I lived on the back of Tokanui Hospital on a Ministry of Ag and Fisheries farm and it was a 500-acre farm. My partner at the time was a shepherd on this farm. I had a horse, named Alice, and black Labrador, named Lucy, and we had free range of the farm, and for my own relaxation I used to saddle up Alice and we would go around the farm and on this particular day -- I'm sorry, Michael, I've forgotten the date, I know it was in 1991, I believe -- interestingly, before that, I would jump my horse Alice over this fence into a paddock and my black Lab Lucy used to run all the way around the perimeter of this paddock. She would never -- and all the other fences she would climb through the fence and chase after us, but this particular paddock she would run the whole perimeter around and would never come through this paddock with us. I jumped Alice and we landed on the ground and her -- one of her forelegs went straight down a hole, we tumbled over, and as I fell I felt my elbow hit something hard in the ground and sat up and realised that what I thought was a rock was a headstone. It was a plaque. And it said, "In loving memory of" and I won't repeat the name. And I picked it up and I was very confused about this, and so I went, we went home and -- so when I say I lived on a MAF farm, it was a cluster of

housing at Tokanui what was for the staff of Tokanui, so the Area Health Board provided cheap rental housing for staff.

So I went across to my next-door neighbour who was a clinical psychologist, a close friend of mine, and showed her this plaque and I said, "What do you make of this?" And she said, "I think this might be part of the paupers' grave." I said, "What are you talking about?" I had no knowledge of this.

To cut a very long story short, on the following Monday this psychologist friend went to the bake house, which -- it used to be the old bake house at Tokanui but it turned into a storage area for medical and other historical records – and she found the name that was on this plaque who had been buried in the paupers' grave. Not only that, she found the plans at that time of just under 500 people who were buried in that paupers' grave.

So I had been riding, not just me, everyone who worked on the farm, had been -- that paddock had been grazed with sheep, it had been grazed with other animals, it was run as a working farm and there was no knowledge of these people buried there.

So when we looked at the plans it was incredibly shocking, they were arranged into "protestants", "catholics", "unknown", "Māori", and "other ethnicities".

What happened next was that the powers that be contacted the iwi and by their -- some of you will be familiar with the process that unfolded about getting this paddock re-fenced and erecting a memorial to the 500 people that were buried there.

Q. And you've been back since, I understand.

A. Yes.

Q. And that memorial is there. It's still largely just an unmarked paddock, it's fenced; is that correct?

A. That's correct. I've been recently back there in the last couple of months. It is still -- there's a beautiful black stone memorial there with all the people's names on but essentially it still lacks the look of a graveyard. It is on the slope of a hill, there are no crosses or flowers or markings to identify that there's a graveyard there, just the memorial.

From what I know, the paupers' grave ceased being used in about 1967, so not so long ago.

Q. Thank you for sharing that. Just in the interests of time, we'll move on to another topic which is, I want to ask you about what would happen if you tried to report something that you witnessed at Tokanui, abuse or neglect. What would happen if you reported that to a senior staff member or anyone there?

A. Any type of advocacy or reporting was rendered illegitimate, because the unspoken was the difficulties caused for me and for others about reporting on your colleagues. So life for me became incredibly difficult. Because I did report up, I did report things that I had seen.

I also learned that it had an extremely negative effect on the people with disabilities that were living in those wards that I was reporting for. So I understand that my nickname was "the Gestapo" and when I arrived on the ward they would call out, you know, "The Gestapo's here, watch out!" And I understand from people who later could communicate, that I had taught to communicate, they would say that the behaviour changed completely when I came on the ward to do my teaching sessions.

But I was ostracised, I was called names, I was left out of staff parties, and on one occasion I had my tyres on my car slashed. So the innuendoes and the environment gave very clear signals: You are not to be a snitch, you are not to report up, because if you do we're going to make life incredibly difficult for you. And that was evidenced to me on a number of occasions. Blocking me from -- so I would go in to bath or -- sorry, to teach this little man to bath and he'd already been bathed and he was sitting there crying his eyes out. So I knew that that was one of the messages to me that, yeah, just to -- so I guess I had to calibrate that reporting into sort of a more covert collection of evidence which transpired, anyway, into not being able to be used.

Q. Thank you. Moving on to another topic again, I wanted to ask about augmentative communication systems that you used in your training officer role.

And we might bring up an exhibit, Madam Chair, exhibit number 601002. We'll have that up on the screen.

It's not the clearest photo to look at to see the detail of that, but do you want to describe to the Commissioners what we see there?

A. So this is one of the, we call it augmentative communication, and it's something I became very interested in, how was I going to equip people with the skills in order to communicate. That became my focus in the last five or six years of my time at Tokanui. I developed a specialist expertise in working alongside people assessing them for a communication device that ranged from --

Q. Just slow down a bit.

A. Sorry. Yes, I get very passionate about it.

CHAIR: Yes, I hear that.

A. So what you see up here is an example of a communication device, it's a very poor example, I wish I had photos of the end product, of a device that we designed for Mr B.

Q. Can you just describe it physically so those without sight can know what we're looking at.

A. So it is an aluminium empty frame, attached to another equally-sized frame that within it held around 12 different coloured overlays. This is a very early example, so you only see three colours up there. This is called an eye gaze display system. It was one that was designed alongside Mr B, who was very clear about what he wanted. The person speaking to him would sit on the other side of the aluminium frame so their face could see a series of numbers that's on the outside, which you can't see, it's on the other side of the aluminium frame, numbered 1 to 9.

This was a design that we worked on over three to four years. So, shall I just quickly show?

QUESTIONING BY MR THOMAS CONTINUED: Go ahead.

A. I know you can't see this but how it operated was a number of grid systems. I can pass it up to you. So Mr B would indicate one of the numbers on the other side of the aluminium frame, and it could be 1. So I would be following his eye gaze, he would look at number 1, and I'd go 1, which would mean that he was speaking about the first grid reference -- it's very simple, it sounds very complicated. The second number that he would give me with his eyes indicated which of the boxes, the messages that he was going to within that grid.

We get to talk about Mr B?

Q. Yeah, I think I should have perhaps done that first. Do you want to talk about him now and how you met him and, yeah, a bit about him. He was -- you picked up that he showed a need to communicate and you developed this for him?

A. That's right.

Q. He had cerebral palsy?

A. That's right.

Q. And please, you describe, you tell us about him.

A. He never came to the training centre, he was someone I passed every day in ward 16 when I was collecting other young people to come over to the training centre and every day I'd walk past him as he was draped over his wedge, he had a very contractured body, he couldn't move any part of his body apart from his mouth and his eyes and I could actually pick him up and carry him. We were the same age, we were both born in the same year.

But I would walk past him every morning and say, "Heya, how are you going?" And he would give me a great big smile, an open mouth. And one morning I walked past him, I said, "How are you doing?", and he had a very pursed mouth, and he closed it. It tweaked me, his eyes and his pursed mouth were saying, "Actually, things aren't okay", and

I went back to him and I said, "Can you say yes and no?" Which was a stupid question really. And I said, "Show me your yes", and he opened his mouth very wide. I said, "Show me your no", and he pursed his lips very tightly. So I immediately went back over to the training centre and said to the psychologist, "This man has to come to the training centre, he's going to be in my class and we're going to start him tomorrow." He didn't, in fact, meet the criteria because he had no viable way of being assessed.

Well, he came over to my classroom, and we developed this eye gaze display system that over probably eight years developed into him having a vocab of just under 3,000 words and phrases.

Now, how on earth did this man learn to read and write and spell? Yes, okay, he did spell phonetically, like, for example, he would spell my name K-a-r-o-l-i-o-n, Karolion, which we laughed about in later years because, indeed, I was a lion for him. But he would lie on the floor of the day room every day, like others, and he would watch Sesame Street, he would watch Play School, he would watch other educational programmes where he learned from.

So another training officer and I spent individual sessions with him every single day, including some weekend time, going through what this man could understand through his eye gaze display. And I know that some people in the audience have seen him in action using it and he was a very sophisticated user. But to be able to memorise the placement of words and phrases -- and this is how he went on to describe the sexual abuse that he had witnessed for himself and others in the ward.

This was one of about -- I suppose about 30-odd people that I worked with designing individualised communication devices. So when we just talked about punishment before --

Q. Sorry, just slow down for the stenographer, thank you.

A. Sorry, I know --

CHAIR: Remember it's getting rather late in the day and I am sure fingers and arms are getting a bit tired so just be a bit careful about that.

A. Of course. I am sorry.

So every device was individually designed. I met a carpenter at Tokanui that loved – had no idea what I was doing – he loved it – and he would design and build me things like clocks on an eye gaze display where the person had a switch and the clock hand moved around and stopped and he'd hit the switch again with his cheek to stop on what the letter was or the phrase was.

So it became my passion, but it also became a punishing process for people who wanted to disclose information, who wanted to talk about their staff members, and unfortunately on many occasions the communication devices were trashed or stolen or somehow lost.

QUESTIONING BY MR THOMAS CONTINUED: Thank you. And for Mr B, learning those communication skills also put him in danger; how was that so?

A. So he was able to report who had stolen the VCRs, who had taken all the good jerseys, who were the perpetrators of abuse, and he would tell me this.

Q. He reported a specific incident of abuse to you --

A. Yes, he did.

Q. -- involving him; do you want to talk about that?

A. Yes, he reported to me that the cleaner on his ward had taken the high-powered vacuum cleaner and after he had had a shower they all thought it was a great joke to put his penis in the vacuum cleaner while it was on and that clearly distressed him, so he reported that to me and I -- the cleaner was fired over that one, thankfully. But yes, that is the incident that occurred.

Q. Thank you. Talking about another aspect of Mr B's life that you discuss in your statement around paragraph 2.94 about – you were asking him what he wanted in life and you talk there about him wanting to explore his sexuality. Can you tell us a bit about that, in summary?

A. Yes. In time I asked him about what he wanted in his life, and he said to me that he wanted to have sex. So again, my naïveté took me down the track of showing him a birds and the bees movie of what that actually entailed. And he was very clear from his body language that that was not what he was seeking. But it was the only word he had to articulate the broad needs he had around being handled nicely, about seeing his body naked, about having some intimacy and caressing that was not of a transactional type. He wanted to know what love was, but the only way he had to say that in his experience was to use the word "sex".

That was a very cathartic moment, that took us, what I'm describing to you was hours of conversation and clarity and understanding from me trying to extrapolate what this young man was talking about, that he was seeking to have love.

Now, he'd been watching Days of Our Lives, and he clearly thought that that's what love and romance was all about. We had to do a lot of work on what that actually meant.

Now, coincidentally, I ended up being his case manager in the de-inst [deinstitutionalisation] of Tokanui and in time he was able to procure the services of an

amazing sex worker who helped him to explore this intimacy and need for love. And for him to see a woman's, you know, body naked that was of a personal and intimate interaction.

Now -- I just about said -- Mr B died in 2012. We always had the conversations that I have his permission to tell you these stories, because he had always wanted to be here to deliver the stories of abuse and neglect around his sexuality. And there's also the video available for the Commissioners called [GRO-B] where he explains it himself on videotape.

Q. Thanks for sharing that, Caroline.

Can I now cover another example, I guess an example or instance of sexual abuse or suspected sexual abuse. You raised a complaint of suspected sexual abuse against a senior teacher at Tokanui. Is that correct?

A. Yes.

Q. The allegations were relating to boys who were at Tokanui who were being taken home on weekends by this senior teacher and were suspected of being sexually abused by that teacher. I understand you supported those boys and tried to obtain evidence of abuse. As explained in your statement, you weren't able to find physical evidence of that abuse, but staff, including yourself, did try and do something to investigate that, what happened, and also prevent any future potential abuse.

Can you tell us, was a Police complaint made about the abuse?

A. I'd just like to make it clear, first of all, though, that this was an allegation against a sen ior teacher at the Education Department.

Q. Sure.

A. So on Tokanui Hospital there was also a separate school – not the training centre – there was a separate Education Department school run by bona fide teachers and teacher aides. So it was an allegation against a head teacher in that environment.

Q. Sure.

A. No, at that time I was not aware that a Police complaint was made.

Q. Did you subsequently become aware of that?

A. Yes, yes, some years later.

Q. Did anything happen to the teacher at the time of the allegations?

A. Well, we couldn't find any evidence, apart from what the young men were able to tell us, but it was never proven. A senior member from the Waipā Community and Training

Centre spoke with him and disallowed him from taking any more children home for the weekends, but that's all I understand that the consequences were.

Q. And he was able to continue teaching?

A. Yes, he taught the same boys, he taught -- he mainly, his classroom had six young -- I'll say boys, they were boys at that time, they were under the age of 16, so he continued to teach them on a daily basis. There was no changes there. The only change was he couldn't take them home at the weekends.

Q. You later learned in 2021 that this teacher was convicted criminally of sexual abuse of two young men at a different, a mainstream primary school. How did you feel when you learned about that?

A. I was absolutely, absolutely floored. I was extremely upset. The young men that went home with him have all since deceased, so finding out in 2021 that prior to his teaching commencement at the special school at Tokanui, there had been this incident. From what I understand, though, the evidence and the accusations and then the proving of guilt didn't happen until sometime I think in around 2019. But what it did do was validate clearly.

I was ostracised and banned from the ward for my suspicions based on information given to me by disabled people that they were being sexually abused. That was too much for the charge nurse. I was persona non grata, I was not to go back to that ward to make these stories up.

But to be validated in 2021, I think I walked about 12 k's from Pukerua Bay in towards Wellington crying my eyes out thinking, "What an absolute injustice", you know, I could be somewhat, I was convinced, I --

COMMISSIONER GIBSON: Can I just ask a question to check that the teacher, after the allegations at Tokanui, he stopped taking boys home but he still was allowed to teach?

A. Correct.

Q. And was part of his role as teacher washing, cleansing, anything intimate with the boys?

A. Yes.

Q. And that was after the allegations at Tokanui, he was still allowed to do that?

A. Yes.

Q. Thank you.

QUESTIONING BY MR THOMAS CONTINUED: Thank you, Caroline.

And that -- learning that at a later date, that still haunts you, is that right?

A. It does. For Mr B, he had some type of covert communication system with these other men that went to the school. Mr B was never allowed to go to that school, yet clearly he had the

cognitive function, the intellectual function to do very well at that school. I asked myself a lot of times during that time why wouldn't he be going to the school? Because he could accurately report and because he now had a very good communication system to be able to report.

Now, I just have to go back on one thing I didn't say about Mr B in the ward.

Q. Sure.

A. When he started reporting who had pinched the good knitted jerseys and the VCR and who was having affairs with who, you know, and who was hurting people, he was threatened. And he was threatened by a staff member that he named to me and said that if he carried on giving out this information they could make his death look like a choking accident. And Mr B clearly believed this, clearly believed this, and he was -- it was then that we made the decision together that I needed to leave Tokanui and I needed to become his case manager and I needed to help him move out. It had gone -- it was – he was now seen as someone who could potentially damage a lot of careers, and he was in danger.

Q. Thank you for covering that. We're moving towards the sort of last part of your statement now, Caroline, and before we get to the sort of more broader questions I want to ask you, are you able to summarise what barriers to disclosure, or barriers to making complaints existed for neurodiverse people at Tokanui if they wanted to complain about something? Can you articulate the barriers they faced?

A. Well, firstly, for most people they couldn't communicate or articulate it in an expressive way that made sense. So there was no complaints process. I'm sorry, there was a complaints process, it was posted on the walls: If you are unhappy in the receipt of your service, here's the complaints process. You had to be able to read that first, understand it, then you had to be able to action a complaint yourself. You had no allies to call on to help you to fill in the form. Nor were you believed. People were not believed when they alleged complaints of being mistreated or disrespected or supported in undignified ways, it was absolutely impossible for them to make a complaint.

It was easy for staff to make a complaint, and incident report injuries and -- but no.

Q. Thank you. Do you want to very quickly cover your involvement with the closure of Kimberley Hospital?

A. Only in just that, you know, the decision was made where could I have the most efficacy in helping people to be removed from a very unsafe and inhumane environment, and I joined the case management team and I was Mr B's case manager who -- coincidentally he fired

me after he moved because he said that I made a much better friend and advocate than a case manager, so I lost that job.

But I cannot tell you what that man taught me, but that was a joyous process, and I am thankful that the men who endured what I now understand to be sexual abuse, and for all the others, that they were leaving a place that was terrifying and traumatising.

Q. Thank you. There's something that you mention in your statement around section 5 about attitudinal traction in terms of changing things for people with disabilities. Do you want to make comment on what needs to happen in terms of attitudes?

A. Only in what, you know – other evidence has provided is that there is still a huge barrier around attitudes towards the competencies, the value, the humanity of people with disabilities. Which I see still prevalent in service-provision today. I think Olive summed it up very well in terms of why this is so.

I think that we have a long way to go in terms of shaping and in stating -- demanding a shift, even within the disability sector about the attitudes towards people with disabilities, their worth, their contribution and their competencies, yeah.

Q. Thank you. You wanted to, I know you wanted to mention a specific more contemporary example around baths. Do you want to talk about that now, it is at para 5.2.

A. Do we have time?

Q. We've got time, I believe.

A. If I was to cite examples, I think this is a good one, of indictments against human rights and against attitudes towards those human rights for people who are in service provision today, and I'd just like to read from my statement if that's okay.

Q. Please do. Just remember to keep your pace slow as possible, thank you.

A. "In September 2021 IDEA Services Chief Executive confirmed via a media statement that they prohibited the use of baths and spas in all of their residential services. They also disallowed the use of any spa pools in residential homes and in other facilities owned or leased by IDEA Services. The reason cited was that there have been significant investigations and due diligence into the risk of using baths in services and a recent court ruling stated that their duty to minimise the risk of baths was greater than people's rights to choose to have one."

So I use this as an example from a couple of aspects. The first one is that there will be no dedicated complaints from people who use services about this. It was based on that there was a drowning in IDEA Services in a bath, so after the investigation this was the outcome. So, you know, there are no more baths or spas.

I find it incredulous that this is a very contemporary example of dismantling people's supported decision-making, not allowing any autonomy or choice in a very fundamental and basic daily need. So yeah, that's all I'll say about that.

Q. Thank you. I wanted to give you the chance now, I guess, yeah, to offer your comments or thoughts on, I guess, what you want to see overall come from this Royal Commission and any sort of, you know, concluding thoughts you want to share with the Commissioners.

A. Just a couple of things.

Paul, you've already touched on the inadequacy of needs assessments. That's something that absolutely needs to change. One of the pieces of work that I'm incredibly proud of with the case management team during the late '80s was the way in which we describe people's lives. The needs assessments currently are based on a deficit model, what people can't do. Their life histories have been lost. There is no description of where they have come from, what their family environment is, what their familial need s are, what their cultural identity is all about, and what their hopes, dreams and aspirations are, and how to achieve those.

Again, the needs assessment process has changed significantly to – as others have described – as an application for funding and support rather being about what a person actually needs in their life.

Also, I don't expect the Commission to solve the problems of the world, but one of the things that I think you could have a serious look at is the auditing process that goes on, the relationship between the Ministry and contractual service providers.

It is, again – if I use the term – very transactional rather than relational. It does not in any way try to uncover or try to dissect, extrapolate what people's personal experiences are like, how satisfied they are living in Government-funded service provision. It is mainly about how the provider is meeting the contractual service standards, the sector service standards. I think there is a lot of conversational work to do around that.

I would like to see in that that how people communicate and are able to make complaints is inherently given as much weight as anything else. In an audit you can prove with pictorial strategies, with other devices that in fact people have the opportunity to communicate, but in my experience, the auditors never, ever see them in use.

I hope that makes sense.

Q. Thanks, Caroline. Oh, sorry.

A. No, no, no, I mean, if I was to choose anything that we'd need to have ongoing conversations about, that would be my priorities.

Q. Thank you. Did you want to talk about the apology, as a final thing, before I see if the Commissioners had questions for you?

A. Just finally, and again, I'll just read from my statement. I wanted to call out to all the children who are now adults that I supported, that I taught, that I cared for, that entrusted me with a lot of personal and intimate journeys. I wanted to reach out to make an apology to these people and go visit them, give them my apology, return photos that I have of them, have a cup of tea with them and just ensure that their lives now are happy.

And I have spoken to managers of service provision about seeking contact details for those people concerned and I have been declined due to the Privacy Act. I just wanted to state that my motive for doing that, as I'm sure the Commission understands, is part of redress and just making sure that their lives are better than what they endured in State care.

So that's really all what I wanted to say, Michael.

Q. Thanks so much, Caroline, and I'll leave you with the Commissioners, their questions, thank you.

COMMISSIONER STEENSON: I don't have any questions, but thank you, very fulsome statement.

CHAIR: I just have one issue. So much of what we've heard from you and from others is the locking away of people with disabilities, the out of sight, out of mind attitude which we now know so well informed the placement of residences and the leaving of children and vulnerable adults there out of sight, out of mind. It would be easy for us to say, "Oh, that was in the old days." I'm just wondering, do you have any views at the moment? Contemporarily, has that attitude gone or do we still live with a lingering or even pervasive sense that it's better for disabled people not to be seen, not to be in the community?

A. I think we have a long way to go. And I think that we need to much better speak with people who have disabilities and understand more about what they want, alongside their families, what they want in their lives, that their personal autonomy can be recognised, that they can wholeheartedly contribute to this design of their own plan. I think that, though, there is a lack of professional training that allows the multitude of stakeholders that meet people in this journey to actually authentically have that conversation. I think there are still attitudinal barriers.

Q. Yes.

A. I think in my lifetime I probably won't see that change. But I think that we have to get better at demanding that and I think we have some great, we have some great documents, the United Nations on the Convention on the Rights of People with Disabilities is a

benchmark that everyone should understand, that the evidence of their behaviour of their service provision should be driven from that premise, that they should be able to demonstrate their values in action, not masquerading them as self-evident when in actual fact they're not. So I think we have a relational issue that can be solved over time with these conversations that will shape and change attitudes.

Q. Do you think there's room here for civic training, civic education? I'm talking about the whole population here.

A. I think so, and I think that, you know, we see that in small snapshots. But we don't see it as a campaign or we don't see it as inherently part of everyday life. If you look at people with disabilities as a valuable employee, there's very few people actually in valued paid work.

If we see the competencies that they have -- look, I think -- you're right, from a community perspective, from a civic perspective, I think we have our best hope, but I also think that the training and how we see values in action, I understand that very few of the service providers now provide training to their staff on the basic values of the organisation and how they expect to see that transmitted into actual physical action.

Q. So that's training and educating people who are actually working with disabled people?

A. Yes.

Q. But also the ecosystem in which those people operate and in which disabled people live needs to be, I would have thought, transformed as well?

A. Yes. I also think that we have taken away, we have People First for example, a great organisation, but they're not given the right resource or accolades or development planning for them to become, for them to show some of the phenomenal work that they're doing. There are no other self-advocacy groups that are run by people who have disabilities.

It's something that Sir Robert Martin talks about a lot in terms of shaping change, and I think from Allison Campbell's testimony in terms of how, when people actually had the tools, the right tools and the support and the resource, how they also contribute to the dismantling of attitudinal barriers. And civic education, the best civic education happens in civic land.

Q. Yes. That's right. And to all of us, and for all of us, I would have thought?

A. Yes.

Q. Thank you so much for that. I appreciate your answer to that and I'll leave you now with Paul.

COMMISSIONER GIBSON: Thanks, Caroline, just a few follow-ups. Civic education and civic land, does that mean in schools? Can it work, can civic education work if kids in schools don't see disabled kids alongside them within those schools?

A. That's a good question, Paul. Yeah, it starts at school. I think civic land includes, definitely includes schools. I'm not a keen fan of special schools, however, so I'm finding that a bit hard to grapple with. What I mean is that community presence is a priority for people to be out there seen being active, being seen as equally contributing members, being supported by their support staff to do so, having active membership to regular membership clubs, to authentically talk and demonstrate progress against this thing that we talk about which is community integration. You know, what does that actually look like? We're nowhere near people having that community presence and being respected for what they can contribute.

Q. Community presence is a form of civic education in itself?

A. That's right.

Q. You talked about babies in Tokanui, was there any consciousness at the time of, as horrific as it is, what happened in these places for five-year-olds and over, that if you went in as a baby, your intimacy needs, your needs for love in those first few years, if they were missed out, any consciousness about how to meet those needs or, later on, how to try to fill any gaps?

A. During my experience during that time I have to say no. No, there was no consciousness, just another indictment of that model, Paul. You know, it was never -- they had a revolving door of staff around them that all brought with them different attitudes and different caring techniques but there was never any consciousness about how to provide a salient environment or a nurturing or loving environment for these children, what needed to be replaced for them in terms of love and kinship and some type of connection to that, I don't remember any discussions happening about that, no.

Q. A lot of -- some of the themes were of intimacy and privacy for men, for women, for those for whom it would be harder to otherwise get. Do you have any further thoughts on that? I notice one of the solutions for Mr B was a sex worker. What should the future of disability support look like in terms of meeting the intimacy and privacy needs of a range of disabled adults?

A. Well, that's a personal approach, but what I would say we need to have the conversations, and at the moment the conversations are not being had about people's sexuality or intimate needs.

Q. Can I ask about the cleaner and that incident, or those incidents, were there other people present?

A. Yes.

Q. So it was almost like a group sexual abuse incident?

A. Yes.

Q. The cleaner was fired; was there any prosecution or anything beyond that to stop that person or any others having any contact with any other disabled people in the future?

A. No, not that I'm aware of. They resumed their work, their shifts, they were there. No.

Q. It was hardly recognised as abuse?

A. I think that if [GRO-B] --oh, I'm sorry, Mr B, had not disclosed it to me it would never have been reported. So what was traumatising about that is what went unreported.

Q. Many people require some form of augmented communication or a greater degree of interest, curiosity from the people they're engaging with. What is to be learned now in 2022 specifically in that area, how does this Inquiry make an impact on those people who may be able to communicate more than what others perceive them to be able to do for those who might not even be perceived to have some "yes or no" communication?

A. You're right, Paul, first of all it needs to be diagnosed as a need. Everyone has a need to communicate, every behaviour has a communicative function. In my view, everyone should have a way of being able to express themselves.

As Sir Robert says to us very clearly, the only way that you get support or be recognised as a need is behaving inappropriately. If you start engaging in significant challenging behaviour because your communication needs aren't being met, then you *may* get referred to a specialist provider. But if you are compliant, if you are labile, if you are quietly sitting in your corner rocking, you're never going to attract that attention or that referral process.

It's dangerous, Paul, because everyone needs a way in which to be able to speak or a recognised repertoire of behaviour that people understand means dedicated things. That's a huge gap, that's a huge gap.

So what is the solution to that? Well, I think that it becomes a mandatory auditing process, that's not the right word, but the audits at the moment don't focus on that level of personalised ability to communicate. In my testimony I ask the Commission to review how many complaints have been made by people who have disabilities within current service provision, and you will find very few, especially from people who receptively understand

what's going on in their world around them, but they cannot actively, expressively communicate.

Those are the most vulnerable, that's where the abuse will be happening; that's where the neglect will most likely be happening, but they have no way to report.

Q. Another area was around things that happen at meal times, processes for eating, feeding, but also you reported on the amount of PEG [percutaneous endoscopic gastrostomy – a feeding tube that gives food and fluid directly into the stomach] feeding of people that left Kimberley and other places.

A. Yes.

Q. What are the lessons today to people in support services. Do people making decisions understand enough about people's needs for food, for appropriate --

A. That's another good question, that's a big question. Firstly, I think that I question the number of people that had PEG feeding processes in place, and that's why I've asked that Explore [Explore Services, the multi-disciplinary team contracted to provide the health assessments and referrals at the time of discharge], provide that evidence as part of the de-inst process about why they were used, because on a number of occasions they were used purely for being able to give people enough nutrients. It was about staff time. I'm not over-exaggerating that, that's what was found.

So your question, then, is around people's current nutrition and eating? Well, again, you know, that's something that needs to be – as part of an authentic look into the quality of people's lives, not from an auditing process, but from a more meaningful perspective about how people are bathing, even if they're not allowed to have a bath. So what else is happening for them? What is their nutrition like? You know, when did they last go to the dentist? When did they last have a mammogram, a cervical smear?

I think that your question is multi-faceted in terms of, how do we actually ensure that people are living a quality of life. The tools that are currently used are inadequate and they focus really on compliance and contractual obligations to disability sector standards. So, yeah.

Q. One final question. You literally stumbled across 500 graves of people who were otherwise lost and forgotten. We can only imagine there might be thousands of others across New Zealand, we don't know.

A. Yeah.

Q. We hear what's happened in Canada recently with changes in ground scanning technology. What do you think we should be doing here in Aotearoa New Zealand around these issues?

A. The other question I had when I went to the grave is how did they die? How did they meet this end? Because when you look at the ages of those nearly 500 people, there were some as young as 35, what happened? I think the oldest one was around 70-odd.

I'm sorry, Paul, I've just forgotten your question.

Q. There may be many unmarked graves around Aotearoa New Zealand, we're hearing bits and pieces of more, what do you think should be happening? How can we honour them, their lives, connect with their families, their iwi?

A. Well, I think there needs to be a dedicated look at the records of some of the institutions as to what happened to these people that died within institutional life. You know, some of the people that were buried in that graveyard were returned servicemen that had come back with shell shock, that had been so deeply traumatised they had been diagnosed as having depression.

The abhorrence of this needs another lens over it and it needs – even I would suggest for Tokanui. Yes, we've got a memorial, but we do not know the history, we do not know how each of those people passed away and why there was no family involvement.

Now, for the plaque that I've stumbled onto, she had a sister who also lived at Tokanui and I became her case manager. When I went up to meet her, the mum, she said, "Yes, my other daughter is buried in the cemetery at Tokanui." This was before I'd stumbled across the plaque, sorry. And I had assumed that it was a graveyard in Te Awamutu, or I had assumed it was -- when we discovered this, the mother had passed away so I wasn't able to -- actually, I was grappling with how I would even begin to tell her that her daughter was buried in a paddock that I had grazed sheep on.

Paul, I think that we need to go back to the – what do we call it? – the baker's unit where they keep all the records and there needs to be some acknowledgement and discussion with iwi about a solution or, as part of the redress scheme, how do we offer an acknowledgement of sorrow or an apology around the treatment of those people who ended up in those paupers' graves?

Q. Thank you. It's just left for me to thank you, I think there's a great chorus of people standing behind us that wish to thank you as well. You did mention Mr B's name.

A. I'm sorry.

Q. He resonates with many of us -- I'm actually glad you did, I'm glad that came out. Thank you for touching, transforming many lives, and thank you so much for coming forward. I know it hasn't been easy, and I know you carry the personal burden of some of what happened in these places, but I hope that you can -- the sense of restoration, of

enhancement of your mana and well-being through this process as well, that we hope that survivors get as well.

A. Thank you.

Q. And thank you for your expertise, your ongoing passion and commitment and for making a difference in the lives of people with disabilities, people with learning disabilities, people with the highest degree of communication needs, and I'm sure it will make a difference for those in the future. Kia ora, thank you.

A. Kia ora, thank you.

CHAIR: We've come to the end of evidence for the day and I'll ask our kaikarakia to come forward.

Karakia mutunga and waiata, Ka Waiata, by Ngāti Whātua Ōrākei

Hearing adjourned at 5.13 pm to Thursday, 14 July 2022 at 10 am