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1           **Hearing opens with waiata Whakataka Te Hau and karakia by Ngāti Whātua Ōrākei**  
 2   **[9.40 am]**

3   **KAUMATUA:** (Waiata Whakataka Te Hau). Tihei mauriora ki te whaiaio, ki te ao mārama, tēnei  
 4       te toru atu ngā ringa ki a koe ihoa o ngā manawa. No ngā manaakitanga iuhea ki rungia a  
 5       mātou i ēnei wiki, ēnei rā i tēnei wiki. Tena ka tuku ngā whakamoemiti, ngā whakawhetai  
 6       ki a koe mō tēnei rā i runga i te ingoa tapu Ihu Karaiti, ake, ake, amine. E noho.

7           He aha te hau e wawara e wawara, hetu heraki, hetu heraki. Anana i a mai te pupu  
 8       tarakehe ki uta i tiki natu e au te kotu, hoia te pou whakairo ka tū ki Waitematā, ka tū ki  
 9       Waitematā. A iuku wairangi e, tihei mauriora.

10          Ka mihi tonu rā ki te runga rawa me wehi ki a ia o te rā ki a tuku ngā kupu hōnora  
 11       ki te Kingi Tūheitia ki te whare ariki, he pouherenga waka, he pouherenga tāngata, he  
 12       pouherenga whakaaro, nō reira, kahui ariki rirerire, paimārire.

13          I runga i tēnā kahuri ngā whakaaro koia rātou kāore taia tinana mai rātou, ki tua o te  
 14       arai, ka mihi tonu, ka tangi tonu, ka mihi tonu, ka tangi tonu. Mākū tonu te whenua ki ngā  
 15       roimata mō rātou kua wehe, te toku maha o rātou ngā rangatira, ngā teitei o te whenua.

16          Ko Matua Joe tēnā tetahi hoki o Whātua mākū tonu te roimata ki ngā kakahu taritari  
 17       ki runga i te whānau pani. Tēnā ka mihi ki ai ia o te rā ngā mate katoa, kei runga i a mātou  
 18       pokowhiwhi, o koutou pokowhiwhi.

19          Nā tēnā ka tangi te titi mai tāwhiti kua henga te tetahi anō, ko Ricky Houghton tēnā.  
 20       Te tangi o te ngākau ki tana wehenga atu, me te kōrero mai o te kūmara ka hoki atu ia ki  
 21       tona marae ki Muriwhenua, takoto ai.

22          Nō reira, koutou o Te Tai Tokerau ana te Hine koutou o tērā takiwā, ka tangi te  
 23       ngākau mō koutou te wehenga atu o te rangatira rā. Nō reira, e te rangatira, haere, haere,  
 24       haere, hoki atu.

25          A rātou ki a rātou a tātou ki a tātou, tēnei te tū Whātua ki te mihi atu ki a koutou kua  
 26       tae mai. Me pēnei te kōrero, ko Tupuriri te tāngata e tū ki runga i a Takaparawhau, engari  
 27       ko Tumtumuwhenua te whare. Ko hoki atu ki te rā ingoa Tumutumu ā tika ana ko tērā  
 28       ingoa Tupuwhenua no koutou Te Tai Tokerau. Nō reira, ka mihi a Tumutumuwhenua ki a  
 29       Tuputupuwhenua i to koutou taina mai, tēnā koe, tēnā koe te whaea koutou o Ngāti Hine,  
 30       Tai Tokerau, nau mai haere mai, hoki mai.

31          Wai hoki ngā kōrero o nehe ki tērā rangatira mātou ko Tupuriri, i tana taenga mai ki  
 32       Tāmaki a ka noho ia ki te maunga o Maungakiekie, ko tana pa ko Hikurangi, ka mea  
 33       Hikurangi, ki a Hikurangi. Pai ake tērā Hikurangi. Te whitinga mai o te rā, āe, tika.

1 Nō reira, ka mihi tēnei kanohi o Ngāti Whātua ki a koutou kua tae mai otirā ki a koe  
 2 i te purangi ra Tristram, Ngāti Porou, Ngāti Kahungunu tēnā koe. Koutou katoa ngā  
 3 rangatira i te me kite te paepae kai awaha te tēpu tapu, tēpu mōhio whakatakato o koutou  
 4 pekenga o koutou wheako, o koutou mātauranga ki a mōhio ai te hunga nei, ahuatanga i  
 5 pangia te ao Māori otirā tātou nei iwi Māori.

6 Nō reira, ka mihi i runga i te ngākau whakaiti kua koutou, kua tae mai ki tēnei  
 7 kaupapa, ko te kaupapa Ūhia te Māramatanga, koia nā te ingoa tēnei wāhanga tēnei  
 8 Kōmihana, ka hoki ki tērā kōrero anō, nō ngā tupuna. Mate rongo, ka mōhio. Mate mōhio,  
 9 ka mārāma. Ma te mārāma ka matau, ma te matau ka ora. Tērā te whaingā te whai i te ora  
 10 or tēnei kaupapa. Nō reira, i runga i tēnā, rātou ki a rātou, tātou ... a tātou, tēnā koutou, tēnā  
 11 koutou, tēnā tātou katoa.

12 (What is the wind that is blowing. He is reciting a very famous waiata from Ngāti  
 13 Whātua. I extend my greetings to our Father in heaven. And I send out my words of  
 14 acknowledgment to our King Tuheitia of the Kingitanga. So to our ariki whānau from the  
 15 Kingitanga I greet them, paimārire. We remember those who have passed on. We still  
 16 grieve for them and our land is filled with our tears for those who have passed on. Matua  
 17 Joe was one of those, our esteemed elders who have passed on and we think of his whānau  
 18 who are wearing the cloak of grief. And we carry that upon our shoulders, their grief as  
 19 well.

20 And Ricky Houghton is another one who has also passed on. Our heart mourns for  
 21 him who has passed on. And I hear that he will be returned to his home in Muriwhenua.  
 22 So to you of Ngāti Hine, my heart cries that we have lost this esteemed leader. Chief,  
 23 return, return to where you come from, to your beginnings.

24 So here I stand to greet all of you who have come here today. Tupuriri is the  
 25 ancestor who stood upon Bastion, Takaparawhau. But Tumutumu is the whare, is the  
 26 house. Tuputupuwhenua is the name that's from up north, but he became Tuputupuwhenua  
 27 when he arrived here. I acknowledge you here today Ngāti Hine, welcome, come back,  
 28 return home.

29 I'm going to speak about Tupuriri when he arrived in Auckland, he stayed at One  
 30 Tree Hill and his pā was called Hikurangi, a different Hikurangi from where the sun rises.

31 So here I stand as a representative of Ngāti Whātua to greet you all, you too  
 32 Tristram, Ngāti Porou, Ngāti Kahungunu. And I acknowledge all of you esteemed leaders  
 33 on the panel, bringing your knowledges, your experiences and your specialties to the table,

1 and your knowledge of what's going on with us the Māori people. So on that I humbly  
2 greet you and acknowledge you.

3 So the name of this commission is Te Māramatanga. From learning comes  
4 understanding and from understanding grows knowledge and from knowledge we're able to  
5 use this to go forward and find the pathway forward. So with this I greet you all here  
6 today). (Waiata Te Aroha).

### 7 KAUPAPA MĀORI PANEL

8 **MR BAKER:** (Te reo Māori - here we are. My first greeting goes out to the place that is now lost  
9 to us. I greet all of you that have come to support the day. My heart goes to my mountain  
10 from home. Hikurangi is the mountain that never moves, but all its people who move  
11 around the country. Here we are upon the Tai of Kahu, Rangitoto and I'm thinking of all of  
12 those who have passed on.

13 We think of that who has passed on, to Ricky who has returned to Muriwhenua to  
14 where he's from. Acknowledging those upon the Kaipara who have passed. The Kaipara  
15 Sea cries and mourns as we do also on the submit of Hikurangi, we cry for those who have  
16 passed on, for those who have gone on to the great distance. Up here on One Tree Hill and  
17 here we have here beside us from Ngāti Hine.

18 I greet you all, I greet you my relation who settled us in here today. And you're  
19 talking about Tupuriri and acknowledge the size of Ngāti Whātua coming down from the  
20 Kaipara. I'm thinking about those whānau from Muriwhenua and Pāroa also coming from  
21 the Waiapu. That's us here today.

22 We as Māori have come here to support this kaupapa today for our whānau, for our  
23 families to do what we can see on the wall behind us, this is what we're here for today. It is  
24 a heavy and a very sad subject matter we're talking about today.

25 So I greet you and acknowledge you all. And I turn to this sister of mine from  
26 Ngāti Hine, tēnā koe, greetings to Moe. So we are here to find the way forward for our  
27 people. Kia ora koutou.

28 Welcome everybody, it's nice to see everyone. As you know, Baker's the flashiest  
29 Māori name on the East Coast, (te reo Māori - kia ora Julia, yours and my ancestor, we  
30 share the same ancestors). Tēnā tātou. We're going to sing a song. (Waiata - my gaze  
31 flies with the rays of the sun, is enlightenment for the world. To all of you here, my  
32 greetings fly. Welcome, welcome and I greet you all).

1 **COMMISSIONER GIBSON:** Tēnā koe Matua Wyllis. Nau mai piki mai haere mai. Welcome  
2 to the last day of the hearing on disability and mental health and Deaf, Ūhia te  
3 Māramatanga moving into the light.

4 Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand. It's about  
5 all of us, it's the responsibility of all of us and it's a promise of two peoples to take the best  
6 possible care of each other. And the Abuse in Care Inquiry, our terms of reference ensure  
7 that all that we do is underpinned by Te Tiriti.

8 Two of three priority population groups that we look at are Māori and disabled  
9 people, so it's fitting today that we finish our Inquiry by focusing on these groups, hearing  
10 from people's lived experience, people with expertise in the area.

11 I'll now hand over to Ronelle who's going to facilitate for the day. Kia ora, good  
12 morning.

13 **MR BAKER:** Good morning, tēnā koe, Commissioner Gibson, tēnā koe Commissioner Steenson.  
14 On behalf of the panel, we would like to extend our warm greetings to you this morning.  
15 Nō reira, tēnā tātou katoa, ka mihi nui atu ki a koutou, ko Ronelle Baker ahau, he uri no  
16 Ngāti Porou me Ngāpuhi tonu. No reira, tēnā koutou katoa. (I extend my warm greetings  
17 to you all. I'm a descendant of Ngāti Porou and Waikato-Tainui and Ngāpuhi. With this  
18 I greet you all).

19 It's my honour and privilege today to be the facilitator for our Māori panel and as  
20 Commissioner Gibson has stated, this is the final day of the hearing for Ūhia te  
21 Māramatanga, the disability, Deaf and mental health institutional care hearing.

22 Today we are joined by a Māori panel and in the room here I have my whanaunga  
23 (my relation), Gary Williams, we have Moe Milne, Ron Baker, Karen Pointon, and we're  
24 joined online by Dr Tristram Ingham. Kia ora Tristram, thank you for joining us virtually  
25 today.

26 I'm going to do my best to manage a smooth transition. This is obviously a kaupapa  
27 where we could spend much more than three hours discussing in-depth.

28 So I'd just like to open this forum by acknowledging the survivors who have already  
29 shared their stories throughout the hearing. This is not an easy process to take part in, we  
30 know there are many barriers to participation, and we are just a handful of people here  
31 today taking part in the Māori panel, and we know there are many voices missing from this  
32 process. So we have an important role to play, but we want to acknowledge our whānau  
33 who have already participated and those who cannot be here today.

1           To the panel, ngā mihi ki a koutou. I'd like to begin now by talking about the past.  
2           So in Te Ao Māori (the Māori world) we know that we look to the past to inform the future,  
3           so it is fitting that we begin with Te Ao Tawhito (the old world), the days gone by.

4           We know that disability is not a Māori concept, and that, precolonisation, the ways  
5           that whānau lived and worked together as a whakapapa-based collective were very different  
6           to the experiences of our whānau who were placed into State and faith-based care for a  
7           perceived medical or psychological or disability related reason.

8           So I'd like to begin the session first by coming to our pakeke (elders) and ask both  
9           Moe and Ron to share their perspectives from a Te Ao Māori world view around how  
10          whānau were viewed in Te Ao Tawhito. And I'd like you to draw on your experience of te  
11          reo me ona tikanga. Nō reira, I'll hand over to you Moe in the first instance.

12 **MS MILNE:** Kia ora mai anō tātou. Ka mihi ki a kourua Julia me Paul ngā Kaikōmihana mō te  
13          hui i tēnei rā. He tino mea nui tēnei kia noho mai mātou ki mua i a koutou kia rongō ai e  
14          koutou te ia o te reo Māori me te ia o te mauri o te wairua Māori.

15          (Hi everyone. I meet you both Julia and Paul, our Commissioners, for today's hui.  
16          This is really important that we can sit here before you so you may hear the flow of the  
17          Māori language and also feel our perspective).

18          I just want to say just a little bit of history. I'm actually one of the Waitangi  
19          claimants for the rights of people of Māori with a disability to have a Māori life, just a little  
20          bit of background to that, and we're talking from our Māori point of view, it's actually  
21          really --curious for me to try and understand how people who don't have this experience  
22          can understand the story.

23          My tūpuna (ancestor) was Whe. Whe was the extremely strategic planner and  
24          thinker of Ngāti Hine and lots of our areas within where I live, including my house, are  
25          named for the exploits and the stories of Whe. Whe was the son of Hineamaru. Whe was  
26          the son of Hineamaru and he is depicted in the carvings as having been born from her  
27          armpit.

28          And our stories actually tell us that that's the first recording of caesarean birth  
29          within Ngāti Hine and in fact within Ngāpuhi nui tonu. Whe was born from caesarean  
30          section because he was so crippled that he was unable to walk and he was unable to, you  
31          know, have the life that other children had.

32          And so Hineamaru gifted him to the environment and the birds fed him and  
33          kaumatua took care of him, and Whe grew up to be the leader of Ngāti Hine; without

1 question nobody said he's a person with a disability, nobody said he's a person who can't  
2 walk to the next marae or to the next hui.

3 And there are many areas, and so I'll just tell you a little bit of the name of my house  
4 where I live, and we tell the stories so the stories are never got forgotten about our people.  
5 So my house, where I live is called Te Moemoeā. Te Moemoeā means the dream. The hill  
6 at the back of my house is the place where Whe sat to dream about the future for his people.  
7 And with that, once the dreaming had happened -- so my house is Te Moemoeā, so that my  
8 children and all the generations after will never forget that we came from this tūpuna.

9 Where our whānau land is is called Takenui. Takenui means the big business and  
10 we really are people of big business. So it was where --Whe brought all his advisors, all the  
11 people like Gary and all these advisors everywhere to give good information about how to  
12 start implementing the dream. And so that place is called Takenui and that's our bigger  
13 whānau place.

14 To remember all of this, our home is called Te Moemoeā, we have named a  
15 mokopuna Te Moemoeā so that he will name his children, or one of his children Te  
16 Moemoeā, so that we never forget and what we never forget. And we talk about, we don't  
17 actually run around and think whether we're PC or not, we say our tūpuna Whe was a  
18 kopakopa, his legs were so crippled that he couldn't walk and couldn't stretch them out. He  
19 was a kopakopa. One of our whānau name is Kopa.

20 And so it's not oh we shouldn't say that, or whatever, we actually proudly claim our  
21 tūpuna, and that's an example of a little bit -- and that's part of my claim to the Waitangi  
22 Tribunal, is about our right to have these experience and to come from this ancestry and to  
23 come from this. And if you come to Ngāti Hine, as our whanaunga here knows, we have  
24 people --we haven't yet learned how to be discriminatory about our people who have all the  
25 various different types of disabilities so ko tērā, tērā (that's that).

26 Both Ron and I -- Ron can talk more about the mental health stuff -- have been for  
27 many, many years working in mental health, in Māori mental health, in Māori Health, in  
28 actually trying to reinstate our right to actually have mana (authority and status) on our  
29 whenua.

30 And so what does that mean? It means actually recognising that we know what the  
31 solutions to the problems that have been caused by colonisation, by Christianising us, by all  
32 these other influences that have tried to shape us to look like not like us. Some of that's  
33 been successful because I certainly don't look like the picture of what people think when



1 they think about a Māori person, and that's okay. But we're changing. You should see my  
2 mokopuna (grandchildren), they're going to be able to influence a whole lot of things.

3 And so our stories, and we talk about our amount of time in mental health and the  
4 reclaiming of ourselves. And I'll just tell one story here, - I'm a storyteller by the way,  
5 I used to be a teacher as well, and I have 16 mokopuna, and I live in Matawaia - -- one of  
6 our stories, I do tell - the person at the moment who is chairing the -Nōku te ao (mine is the  
7 world), which is the Māori mental health consumer led movement; when we first came into  
8 a relationship, her greatest desire was to do a karanga, and she had never been brought up  
9 with te reo- Māori or Te Ao Māori. So we did some training, wrote it down, and then didn't  
10 get the confidence. And her first karanga was with her paper like that saying haere mai and  
11 that. This person is now the main kaikaranga at Waitangi Marae. And I honour her --Tui,  
12 this is --and I honour her work that she's done, by reclaiming being Māori she has actually  
13 now found her space of oranga (well-being) as well. so, ki a koe mō to mental health (up to  
14 you now to talk about mental health).

15 **MR BAKER:** Kia ora Moe, e mihi ana tēnei ki a koutou hoki nei o te tēpu, tēnā koutou. (I greet  
16 you all at the table over there). Moe and I have been nurses for over 40 years, I think  
17 you're longer than me eh?

18 **MS MILNE:** Yeah.

19 **MR BAKER:** 41; in this hauora (health) space. Kia ora Moe, they're wonderful stories of our  
20 tūpuna. One of the stories I used to tell Ronelle was about her tūpuna who came on from  
21 Tainui, tōna whaea nō tērā taha hoki nei o te waka Tainui (her mother is from Tainui), and  
22 it's about Karangahape. Hape was supposed to come on the waka Tainui but there was no  
23 room for him. Hape went to the whare wananga. Pai hoki ana te whakamārama ki ngā  
24 kaupapa mō Tangaroa. He knew all of the whakapapa and the kaupapa that belonged to  
25 Tangaroa (and the understandings and knowledge of Tangaroa, the sea). Hape came to  
26 Aotearoa, and he arrived here before Tainui, and he came on the whai, on the stingray, and  
27 he landed up around over here. And when Tainui came down the Tāmaki River and went  
28 across into the Manukau, Hape was standing on the hill back at the top of Hillsborough,  
29 karanga ake ki tona whānau e rere haere ki runga te waka i kī rā Karanga-a-Hape. (He  
30 called out to his relations coming in on the waka. The call of Hape).

31 Hape means to have a club foot, different foot. So he was a disabled person, if you  
32 want to put it in another way. It's part of the reasoning he was not excluded from going to  
33 learn the whare wananga or all the other things, but he got excluded because they taught  
34 something of him coming in the waka, but karanga-a-hape. Ka mau tonu hoki ēnā kōrero

1 kei runga te wāhi nei (those stories are entrenched in this place), which was tied closely to  
 2 the waka Tainui. And I used to tell this story to Ronelle because that's part of her  
 3 Tainuitanga (part of her Tainui connections).

4 And it's not about, it's been part of, we never excluded anybody. We thought they  
 5 would have something which is different to the normal person. And in fact, part of what  
 6 Moe's talking about, ngā waewae kopakopa (crippled legs).

7 If you look at tiki, that's the one reason I wore this, this manaia, if you look at the  
 8 hei tiki, a tiki looks with a pēnā kē rā. Tiki was a taonga, and we used to prize that not for,  
 9 not for not for the āhua o te tinana but he mea kei roto (not because of what it looked like  
 10 but because of what it represented, what was inside). Often, they developed another  
 11 taonga, another asset which was the taha wairua (spiritual side), the ability to be able to live  
 12 and to contact Te Ao, the taiao (the environment) and be in touch with those with us and  
 13 give some direction to the people. So it was a valued, it was a valued place, we placed our  
 14 tūpuna; not one where we cast them aside, we added value to everybody who was born into  
 15 the whānau.

16 And they often were the directors of care and directions of what the iwi, what the  
 17 whānau was going to do. So we have a history which goes back thousands of years of us  
 18 including our whānau in all things.

19 **MS MILNE:** I just want to comment, you see how it's difficult for us to talk about people who are  
 20 different, or people who have a disability. We learn to do that in our professional life.  
 21 That's what the systems actually do to us. But in our lives, in our real lives we actually  
 22 don't talk about that.-- I think about the hunga turi who's part of our whānau as well, hunga  
 23 kapo (those who are deaf and those who are blind) who's part of our whānau, but it's not  
 24 until somebody asks us to do stuff like this that you then identify them as Turi, they  
 25 actually stop being our whanaunga. And when I met my whanaunga here this morning the  
 26 first thing is, how do we connect, not how do we be different, is how do we connect, so  
 27 how do we have a relationship.

28 Sorry about that, but I have to add this other little story, yes, it's my Ao Māori point  
 29 of view. So I just want to, --but we also know our Pākehā whakapapa (European links).  
 30 And one of my Pākehā tūpuna, and we know how to do our whakapapa Pākehā, it's similar  
 31 to our Māori whakapapa. But one of our Pākehā tūpuna was Constable Maxwell Walker  
 32 who was sent to quell the uprising on Karangahape Road. Our history as well, we say that  
 33 really sort of quietly.

1 **MR BAKER:** Tēnā kōrua (acknowledge you both). On that note, before we start sharing stories  
2 of Karangahape Road, we shall move to Gary. So I think a couple of points that I'm  
3 hearing coming through from your kōrero, in particular I like the word "value". So I think  
4 if we think about the timing of colonisation and the idea that people perhaps were not  
5 productive or contributing members of whānau or society, there's this concept of value  
6 that's coming through for me, but also in terms of whānau and whanaungatanga, that core  
7 value of what actually is important. And when we start labelling people and looking for  
8 difference, we are missing the point really.

9 So Gary, I'd like to come to you now and hear your view on this. What do you  
10 think your experience would have been if you were born in pre-colonial times and is there  
11 any whakaaro (thoughts) you'd like to share on this matter?

12 **MR WILLIAMS:** Tēnā koutou. (Gary's saying his mihi). Ngāti Porou is his iwi. I just want to  
13 give some context about why me sitting here today. So I grew up in Tokomaru Bay, I was  
14 fortunate to know people like (inaudible). We used to go to watch kapa haka, we used to  
15 spend lots of time at the marae. I was obviously part of the community there. But they  
16 knew that I was never going to be the halfback of the local rugby team, although I did have  
17 an opinion about everything that the halfback ought to do.

18 So my role was always going to be the seeker and the planner and making sure that  
19 stuff got done my way, because my way was always going to be the best way. You can  
20 imagine that my world changed when I was 13, when I was put in care through no fault of  
21 my own and no fault of my whānau, but it was the system's response to what the system  
22 needed to do to let the system validate its existence.

23 So going back to your question, Ronelle, if I had had been born precolonial times,  
24 my life would have been different. I wouldn't have been seen as different, I may have been  
25 seen as special, because that's how my ancestors would have treated me. But I was never  
26 going to be seen as different, I was never going to be sent away for 20 odd years to live in a  
27 system to help the system be the system. It would have been so much different for me and  
28 my children and my grandchildren.

29 **MS BAKER:** Tena koe Gary. I think we will expand on the system-wide issues later on when we  
30 start looking at future focus. But in terms of that interdependency that's set up, the system  
31 validating its own existence through the way it treats us is different and, you know, that's a  
32 really key point that we'll just hold that, bring that through to the kōrero later in the session.

33 And I'm how going to invite Karen to talk about tāngata Turi within their own  
34 whānau, hapū and iwi. And Karen, what do you think is important for the Royal

1 Commission to understand about the role of Turi whānau and how that changed with  
2 institutionalisation; so for example, when children were sent away to boarding school?

3 **MS POINTON:** If I could just ask that I'd like to start with my pepeha today and then answer  
4 your question if that's okay, Ronelle. First, I'd like to acknowledge the other panel  
5 members and I'm so blessed to have you involved today. I'll start with my pepeha.

6 Ko Karen Pointon (nee Nathan) tēnei (this is Karen Pointon (Nathan), ko  
7 Ngatokimatawhaorua te waka (canoe), ko Ruapekapeka te maunga (mountain), ko  
8 Waiomio te awa (Waiomio is the river), ko Taumarere to moana, ko Mohinui ko  
9 Maungarongo ngā marae (are the village), ko Ngāpuhi te iwi, ko Ngāti Hine, Te Uriroroi,  
10 Te Mahurehure ngā hapū. Kia ora everyone.

11 Now going back, Ronelle, to your initial question, sorry, could you repeat the  
12 question again for me?

13 **MS BAKER:** Kia ora Karen. So thinking about the role of Turi whānau, how do you think that  
14 changed when children were sort of sent away to boarding school, for example? Do you  
15 think that the way that whānau were viewed in the old days compared to later on when  
16 institutions were becoming more commonplace, how did things change?

17 **MS POINTON:** I think there were huge changes and massive impact for tāngata Turi. And I  
18 think the reason for that is that iwi, hapū, whānau, really they didn't understand the needs  
19 for those Deaf children, when they were institutionalised. They were institutionalised in  
20 the Deaf School. And it didn't mean that whānau didn't know how to support them, it was  
21 just the best option that they were told at the time to be institutionalised and sent to school.

22 Prior to that, so there were no Māori at school to help them in those institutions. I'll  
23 explain more about that in one of your further questions.

24 **MS BAKER:** Kia ora Karen, thank you. I'm now going to invite Tristram, thank you Tristram for  
25 waiting patiently online. Tristram, leaders in the disability sector will have the opportunity  
26 to reflect on the experiences that have been shared by our whānau members throughout this  
27 hearing. In your view, what did Te Tiriti o Waitangi guarantee Māori in respect of care and  
28 treatment and to what extent do you think the Crown has met its obligations under Te Tiriti  
29 during the period 1950 to 1999, kei a koe (over to you).

30 **DR INGHAM:** Tēnā koe Rona. Tuatahi, te mihi mahuta ki te pae tupakirirangaranga.

31 Rangaranga ki te po, rangaranga ki te ao, rangaranga ki te tuakiri it tona tapu ki tona ihi,  
32 ki tona wehi, ki te whai ao, ki te ao mārama, tihei mauriora. Tena koutou katoa. Tuatahi,  
33 tēnei te mihi ki a kōrua. (First, I send my greetings that weaved us to the night and the

1 sacredness of us, may we rise above and come into the world of light. First I greet you  
2 both, the two Commissioners).

3 To both the Commissioners and to the Commission staff. Thank you to the karanga  
4 and kaikōrero for today's powhiri (our speaker for today's welcome, I acknowledge you),  
5 and thank you to those who are in attendance and to those who gave evidence as part of this  
6 hearing and to fellow panelists, kia ora.

7 Ko wai au? Ko Tākitimu te waka, ko Ngaruroro te awa, Ko Ngāti Kahungunu ki  
8 Heretaunga, Ngāti Porou ōku iwi. Ko Tristram Ingham ahau, nō reira, tēnā koutou katoa.  
9 (Who am I? Takitimu is my waka, Ngaruroro my river, Ngāti Kahungunu and Heretaunga  
10 and Ngāti Porou are my tribes, and I am Tristram, that is my name, and I greet you all).

11 Thank you very much for the opportunity to be here today and to share in this panel  
12 with you. I think the question is very important, what does Te Tiriti o Waitangi guarantee  
13 Māori in respect of care and treatment?

14 I think it's very clear that Te Tiriti o Waitangi guarantees existing tāngata whenua  
15 right to the well-being for all tāngata whaikaha Māori under all articles of the Treaty, Te  
16 Ritenga declaration and the intent of Te Tiriti o Waitangi.

17 Just for clarity, I use the term, or use the term "tāngata whaikaha Māori" today to  
18 represent an umbrella term for those Māori who, under a western colonial definition, might  
19 describe themselves as disabled, Deaf or experiencing mental health distress, but  
20 acknowledge also that this is not an historic term, nor is there a universal umbrella term for  
21 disability, because disability is not of Te Ao Māori in that sense, and I acknowledge the  
22 kōrero of the other panelists in addressing that.

23 So equally acceptable terms such as whānau hauā and impairment related terms may  
24 also be applied here as well. But I use the term "tāngata whaikaha Māori" to reflect the  
25 term of aspiration, future focus, and a sense of the fundamental tuakiri (identity), the inner  
26 strength, the qualities and purposes of the individuals and their whānau in striving for  
27 positive health and wellbeing pae ora (health standards) outcome. So I use that term  
28 deliberately.

29 The first article of the Treaty gives Māori and tāngata whaikaha Māori the right to  
30 tino rangatiratanga and mana motuhake, not only in a broad State-wide scale, but also self-  
31 determination over their own health and wellbeing. And that is a critical element. We have  
32 not had that right, that right has been removed from us in many cases.

33 The second article talks about effectively the right to self--organise and have  
34 authority over self--management, and that includes the right to authority-- over the

1 development, design, delivery, monitoring and evaluation of health, disability, social  
2 well-being services. Again, that right has been denied.

3 The third article refers to equity, equity with British subjects. And equity is  
4 something --equity in health and wellbeing, in disability outcomes, again, has not been  
5 achieved. And the Ritenga declaration, I guess this links to a point that whaea- Moe Milne  
6 has raised, also includes the right for tāngata whaikaha Māori to have their own faith, their  
7 own ways of doing things, the kaupapa Māori ways, the ways to self-identify, -self-  
8 organise- and to be Māori. And much of the State's actions in this space have removed that  
9 ability to identify and to be, to live Māori.

10 So I think evidence from this hearing, and in particular a lot of background evidence  
11 presented to the Waitangi Tribunal in the disability phase of the Wai 2575 health services  
12 and outcomes kaupapa inquiry, have demonstrated that the Crown has not met its obligations  
13 to tāngata whaikaha Māori.

14 This has not been a one-off or isolated incident. This has been a pervasive,  
15 long-standing, highly systematised, highly controlled approach over many decades,  
16 generations. And those approaches have specifically included the segregation and removal  
17 of tāngata whaikaha Māori from their whānau, assimilation of Māori through suppression  
18 of cultural practises, and attempts to systematically eliminate people who the Crown  
19 considered undesirables on the basis of policies underpinned by the eugenic ideologies.

20 And I don't say that lightly. Evidence has shown that these same government  
21 policies resulting in institutionalisation caused immeasurable damage, those lost from their  
22 whānau, those abused within Government owned and funded institutions. The Crown's  
23 approach overall to disability has been reductionist and ableist. It has often employed the  
24 same strategies of segregation, suppression and paternalism that characterise the Crown's  
25 approach and actions towards Māori in general.

26 However, as we may address later, tāngata whaikaha Māori have been further  
27 impacted due to the intersectionality of disability with colonisation, coloniality and racism.  
28 I think there has been abuse at multiple levels. The system has been abusive in not only its  
29 intent but its implementation, but it has in its implementation created an environment where  
30 power imbalance is the norm, and those situations are rife for abuse to occur at an  
31 interpersonal level as well. Kia ora.

32 **MS BAKER:** Tēnā koe Tristram, whakaae ki tērā (do we agree with that)?

33 **MS MILNE:** Āe.

1 **MS BAKER:** Āe, so you got a unanimous tautoko (unanimous support) here from your fellow  
2 panellists, Tristram, tēnā koe.

3 Gary, can I draw on your personal experience. In terms of what you talked about in  
4 your opening statement, you know, being separated from your whānau for 20 years of your  
5 life, tell us about what the impact was for you personally of being separated from your  
6 whānau, your whenua and culture. Did you ever have any involvement in the decision  
7 making around what was happening to you?

8 **MR WILLIAMS:** Thank you. I found it quite difficult because that's an easy no, because of  
9 (inaudible) that your whānau know what's best for you in those kinds of things. So, they  
10 were encouraged and influenced, they probably regret today because I got isolated, I was  
11 shifted. Matt Whiting was talking about Pukeora yesterday. I was there at the same time as  
12 him. So, you know, my parents visited me once, because it was a 400K drive, it was such a  
13 long way away.

14 When I went into that institution I lost language skills, I had to learn to be Pākehā  
15 because that was the only way the system would acknowledge my existence. I had to  
16 assume the label of somebody with cerebral palsy because apparently that's how they like  
17 to refer to people like me. I am an academic, I like nerdy stuff. I could have been a brain  
18 surgeon (inaudible) but, you know, I was not given the tools to succeed outside of an  
19 institution because the people who were in charge probably (inaudible) worked to their  
20 highest capacities, and for someone like me the highest capacity was not going to do it for  
21 them.

22 So, I lost the learnings that I could have continued because of all this separatist,  
23 racist stuff that goes on within a system that requires people to present in a particular way,  
24 because the system likes conformity and I'm not sure that I can do conformity.

25 Most people think that I can't do conformity but it really, it really sets me off.  
26 I didn't intend to (inaudible). Fortunately, the detour that I took has led me here. So, in my  
27 working life I've been influential and stuff like the disability convention, the disability  
28 strategy. We talk about EGL. If you have a good look at that document, you can see that  
29 they've got my fingerprints all over them.

30 And (inaudible) my teacher, I want to be I-- want to create a foundation that we can  
31 build on with this Commission. I'm hopeful that the recommendations will build on the  
32 foundations I've got, so it's naive to think it's going to solve everything, but there's going to  
33 be some useful tools in the toolkit that other people can use.

1 **MS BAKER:** Kia ora Gary, thank you. I have had a reminder to slow down. I think it's probably  
2 a reminder for me and I apologise to the interpreters that I have been speaking a bit too  
3 quickly, so I shall slow down.

4 And I will now come to Karen again. So, Karen, to what extent was Māori culture  
5 or knowledge included in Deaf Education during the timeframe we're looking at, which is  
6 1950 to 1999?

7 **MS POINTON:** It's a really good question, Ronelle. So, 1950 to roughly, let's say, 1990s there  
8 was nothing, nothing at all. There was nothing in the school curriculum, there was nothing  
9 taught about Māori culture, Te Ao Māori, te reo, nothing. But from 1992 we had a Māori  
10 hearing worker at the Deaf School, and if you can imagine how amazing for Māori Deaf  
11 and Pacific Island students, they were just absolutely engaged having a Māori teacher. And  
12 getting involved with that teacher, that had a huge impact on and-- the culture changed.

13 From 1992 onwards to 2017, things really sort of decreased in that area. And that  
14 impact now is, you know, we really need to employ more Māori staff, so that they can  
15 create that connection with the Māori Deaf students. And with their whānau and their iwi  
16 and their hapū so that everyone can be more included. So, with Māori teachers to support  
17 that connection.

18 There is one Māori staff currently. It is not enough. I really believe that the  
19 Government needs to commit to that, that they need to commit to employing more Māori  
20 staff, so that they can introduce and influence Te Ao Māori, te reo, and Māori in general to  
21 create that partnership. That is the goal, that is essential. But from now, from historically,  
22 there just has not been enough.

23 **MS BAKER:** Kia ora, thank you Karen. I guess just following on from that question, what do  
24 you think the impact is if our children who are being educated in Deaf schools, for  
25 example, if they don't have the connection to their Māori cultural identity or te reo Māori,  
26 what do you think the impact of that is?

27 **MS POINTON:** I really feel for those Māori Deaf students, it's essential for them to have access  
28 to Te Ao Māori in school and it's just not there, so that they then can be involved with their  
29 whānau and their iwi and hapū. And the problem is, there are massive barriers for these  
30 children and that's because there are no trilingual interpreters to help them to access and  
31 absorb their own culture.

32 So Deaf School, you know, there's none there, they have a policy about it, but in  
33 practice, it's just not happening. It's really critical for these students to -be able to immerse



1 themselves and have that benefit to achieve their own goals and to- become more connected  
2 with their Māori culture and their Māori world.

3 **MS BAKER:** Kia ora, thank you. We'll talk a little bit more about your vision for the future of  
4 Deaf Education in our later segment of the hearing. Tēnā koe Karen.

5 I'm now going to come back to Ron and Moe as we talk about the impact of  
6 historical abuse on Māori iwi and hapū. Ron and Moe, both of you have dedicated your  
7 career to improving models of care and to integrating more culturally appropriate  
8 approaches, particularly within Māori mental health services. You've both been involved in  
9 deinstitutionalisation processes and the closure that took place of physical premises and of  
10 the psychiatric and psychopaedic hospitals where a lot of the abuse took place.

11 Moe, I'd like to come to you and ask you in your experience working in these  
12 institutions, what was it like for Māori within these institutions? Do you think racial  
13 discrimination was a factor when the abuse occurred?

14 **MS MILNE:** I just want to make a comment, I really want to make a comment first. The status  
15 that we're in as Māori right now right now is not our fault. I really want to make that point,  
16 because often when we come to these hearings there's actually an assumption and- kia ora-,  
17 Tristram, for that analysis, -there's really an assumption that we've got to actually fix- this  
18 up.

19 And I'm really, really quite convinced that racism is actually a problem that wasn't  
20 created by Māori. And therefore when we're having these conversations and because we  
21 can tell you, we can tell you all the stories that we did behind closed doors and after hours  
22 where, because we were so aroha for our people in these institutions as workers now, as  
23 mental health workers, as people who are working in this whole area of disability, we  
24 probably would have got the sack if people knew what we were doing as Māori kaimahi  
25 (Māori workers) to honour the mana or the whakapapa that people came into our care with.  
26 Because we are the people who know about people being locked up forever, you know, and  
27 we'd wait until everybody's gone and then we'll go and open the door and give them a cup  
28 of tea, type of thing, because we couldn't. We were the ones who took after everybody had  
29 gone the big pots of kai in so that we could have boil up with the "mad" people, or with all  
30 those patients who nobody knew where they belonged.

31 We can kind of do that, but the thing that's actually really worrying for me when we  
32 start engaging in these kind of things, --I did a presentation in Sydney one year in the  
33 mental health conference, and my question was, why don't they get it? The issue has  
34 always been almost like our burden, and my question is, why don't they get it? What do we

1 need to do? Because those people who were in those institutions, they were  
2 deinstitutionalised, they were actually literally sent out on the street and left.

3 I live up north, well, I lived -went back up north, I worked in Carrington for a while;  
4 when they deinstitutionalised Carrington,- they sent all these people home, all these people  
5 back to their whānau. And guess what? Whānau didn't know who those people were.  
6 Those people did not know who their whānau were, because they were plucked out of their  
7 whānau, put into these institutions for crimes such as wanting to go and get a job in  
8 Wellington, type of thing, and they were deemed to be mentally unstable, vagrancy, all  
9 those sorts of old-fashioned terms were being put on people.

10 The other thing that constant -- and we're still involved right now, in the way in  
11 which people are diagnosed and incarcerated; because the system incarcerated, all the ways  
12 in which the assessments are done don't take account of ngā mea Māori (Māori ways). So,  
13 they come into our gambit and we, as the Māori workers, then spent an awful lot of time  
14 trying to almost apologise for the system, and I'm just thinking about what you were saying  
15 Gary, getting lost, -we're almost like apologising or doing, you know, if nothing else fails,  
16 me aroha, aroha ki te -tāngata (always show love and care). The only tool in the end that  
17 we had in our toolbox was aroha, because everybody else had the power, everybody else  
18 had the power of the pen and everybody else made the decisions about what happened to  
19 those people.

20 You know, I'll say it even though I don't know if I'm supposed to or not, that  
21 apology that came from our college last week, you know, to the people out of Lake Alice,  
22 you know, we actually looked after those people, and we said this is not right. But we also  
23 were powerless in the situation to actually make the changes, but we didn't give up. And  
24 one of the things that we have to actually really celebrate is that we didn't, even though you  
25 were lost for 20 years, Gary, you're still here, and we're still tumeke (you're still amazing).

26 And I don't even think it's resilience, but it's actually a passionate hope for the future  
27 that what we do is actually going to have some benefit for our mokopuna, actually our  
28 mokopunas' mokopuna. That's our planning, that's the way we're thinking. I'm an uri of  
29 Kawiti. Kawiti was deemed to be a rebel, Kawiti signed the Treaty of Waitangi. So our  
30 whānau and our hapū are responsible for keeping the conversations about Te Tiriti o  
31 Waitangi alive because that's our great, great, great grandfather type of thing.

32 And he actually said you need to keep continuously planning for five generations  
33 hence. And today, we're contributing to hopefully conscientising the powers of, whether  
34 it's government or legislation or policy or whatever, we're hopefully conscientising that that

1           there needs to be a change, that Māori as tāngata whenua have actually been given a raw  
2           deal and that we do have places to play and a role to play in all our own oranga  
3           (well-being) and it took us, -everybody said what a great idea, deinstitutionalisation. Then  
4           we had people who really, -really we- had people in Auckland down Queen Street, and then  
5           everybody was frightened of them because they're all mad people, all those mental health  
6           people have been let out. And so- we were going to pick them up, get blankets, all those  
7           sorts of things.

8                         So, deinstitutionalisation, what a great idea, get everybody out of the looney bins;  
9           where to? Because they weren't given back properly to their whānau and whānau didn't  
10          know they were there. And we've had to also be guilty of letting whānau know, because we  
11          also do know of people who were taken into care and their whānau didn't know what  
12          happened to them. They went and they'd disappear for 20 years without the whānau  
13          knowing where they'd been taken to. Deinstitutionalisation really brought those kind of  
14          traumas up. Yeah, that's a whole issue on its own.

15       **MR BAKER:** Kia ora Moe. I just wonder, I've got a question for you, Karen. In 1992 I was part  
16          of -- the Kelston Deaf School went on pōwhiri at Hoani Waititi. Were you part of that?

17       **MS POINTON:** No, I wasn't there at the time, I think Carol was there.

18       **MR BAKER:** It's one of the things which sticks in my mind, that we went on - they came and got  
19          me because I was the speaker for the school. And what sticks in my mind is the waiata  
20          tautoko, when we sang Wairua Tapu. The only personal singing was me; the rest was done  
21          a ringa-. And it's one of the most stunning things that sticks in my mind about how we  
22          involve our people with ourselves. It's not something, --it's an inclusive thing, it's not  
23          something that, --they were part of our whānau so we were just saying hello, we were  
24          coming together as part of that time. So kia ora rā.

25       **MS POINTON:** Kia ora.

26       **MR BAKER:** And I go back to that often when I'm talking about those sorts of things, because I  
27          can tell you lots of different stories too. But I want to make three comments.

28                         One, the first one is about the law. From 1950 to 1972 anybody could be admitted  
29          into a psychiatric or psychopaedic hospital, and you stayed there, and the law said "at the  
30          pleasure of the medical superintendent"; not if you got well, not if you got cured, but at the  
31          pleasure of the medical superintendent.

32                         And I'll tell you how many people got discharged from those places; none. And like  
33          Moe was saying, they just gathered all these people up from Māori villages on the Kaipara,

1 around Auckland, all these rural places, even back home and they took them all into places  
2 such as Kingseat up here and Mangere Hospital.

3 **MS MILNE:** That's right, tautoko.

4 **MR BAKER:** All those places down -what's that one, that- Kimbolton or something, they had a  
5 big one down the middle --

6 **MR WILLIAMS:** Alice --

7 **MS MILNE:** Alice Springs.

8 **MR BAKER:** Yeah, Alice Springs and all those places in the South Island.

9 **MS MILNE:** Lake Alice, sorry, Lake Alice

10 **MR BAKER:** And they just admitted them, and once you got in, you were at the pleasure, --the  
11 medical superintendent was bigger than God. At least God would help you get well. And  
12 things changed when we had those big strikes in 1972 and they changed the law.

13 **MS MILNE:** Also, when they changed the law, just let me tell you, and this was all this big thing  
14 about --that was the 70s, and then in the early 80s they did all this economic development.  
15 And you know what happened at that time, we were then-- had this massive like 180%  
16 increase in Māori incarcerated and mental health institution, well, can't call them mental  
17 health institution because they weren't around health, they were about illness. And there  
18 was a big increase up to 93. And then there was another big increase in the early 2000,  
19 2004 area.

20 **MR BAKER:** Yeah.

21 **MS MILNE:** Yeah, and you know, I don't know if this is in the Commission remit, but the way in  
22 which policies and decisions are made are not actually considered what the impact on  
23 Māori with mental illness actually is.

24 **MR BAKER:** Yeah, my other point is this. In 1990 I became the manager for the kaupapa Māori  
25 health services in Auckland. One of the major reasons for deinstitutionalisation was  
26 money. Carrington Hospital, for every dollar that went into Carrington Hospital 65 cents  
27 went to the bricks and mortar, went into the building, which only left 35 cents going into  
28 care. And there was no likelihood that it was going to increase or decrease. So it became a  
29 big millstone around the DHB's neck.

30 The easiest thing to do to remove their \$60,000 or \$70,000 deficit in 1990 was to  
31 sell the property. And that's what they did, they sold it to --Unitech.

32 **MS MILNE:** Looneytech (laughter).

33 **MR BAKER:** To Looneytech, which by real means, the 500 acres should have gone back to Ngāti  
34 Whātua because it had changed the things. At that time Ngāti Whātua, the rūnanga said

1 they would include it in the general application or under the Waitangi Tribunal for the  
2 whole of Auckland, but it never happened, but that's another story.

3 So they closed Oakley and Carrington Hospital. They had 30 people left out of the  
4 closure, like Moe was saying, our people were all sent back either to other places around  
5 the country, or were sent home, or to boarding places or other places around the whole  
6 country. They were left with 30 people for which they put into one ward, closed the door,  
7 and walked away and left them there.

8 Of those 30 people, 23 of them were Māori, the others were all Pacific Island  
9 descent. The staff refused to look after them. So the medical superintendent of the DHB,  
10 plus the chief nurse had to go and look after them, Anne Murphy, and what's his name, Les  
11 Honeyman at that time. They were the two people who had to go and develop some care.

12 As part of that we got Whare Paia because they couldn't find ways of looking after  
13 these people who had been incarcerated for so long and had nowhere else to go, so they  
14 developed Whare Paia and from that Titewhai Harawira came down --they came back to us  
15 as a people, for example, because they had nowhere else to go. And under the union rules,  
16 no other nursing or medical care was going to be delivered to them. They had full-time  
17 care at that time, they just closed the door and left them there.

18 For my sins, I was the last manager of Whare Paia and we closed that as part of the  
19 vacant possession to Looneytech, of that whole site. And we developed a service as part of  
20 that, I'll talk a bit more about that as well. But that also sticks in my mind about how the  
21 system eventually deals with us, that it looks after us, incarcerates us and then --

22 **MS MILNE:** Can I make a little comment on that as well. So when Whare Paia, --Whare Paia  
23 was a necessary part of Māori mental health development. But when it was closed  
24 down -- and this is where you get all the anomalies eh -- it was deemed, because it was too  
25 violent, or things that were not right happened at Whare Paia and they were deemed to be  
26 violent.

27 Nobody looks at the other system and the violence that's deemed or delivered on our  
28 people in institutions or in services. But Whare Paia, everybody went it can't be right, this  
29 is a Māori institution and they're violent, therefore we've got to close it down, you know,  
30 and they don't close down other institutions who have violated our people for a long time.

31 **MR BAKER:** Yeah, and my third point is this: One of the young fullas they had that came to  
32 Whare Paia came from the closure of Kingseat. This young fulla, they had difficulty, like  
33 Moe was saying, handling him. So they used to get three male nurses and they would hold

1 him against the fence and they would wash him outside with a hose because he became too  
2 difficult for them to handle.

3 When they closed down Kingseat they sent him to Whare Paia. Our way of looking  
4 after him, I thought it was one of the innovative things, and we did it all the time that I was  
5 there too, it took us three years. But whoever happened, --we tied one of those cords for a  
6 gown, you know the dressing gown cords, we tied it around his waist; and every time he  
7 got agitated or he got out of control, whoever was nearest to him would grab him, take the  
8 cord around his waist and wrap his arm around yours. And we would drag him outside and  
9 there's a hill just outside Whare Paia and we would run him up the hill, whoever was  
10 nearest, they would keep running up the hill until we ran the energy out of him. That's  
11 what we did, we did that for three years.

12 Every time, slowly but surely, he came inside and sat down at the table and was able  
13 to eventually eat with us, talk with us. But that's what we did. You reuse the energy in  
14 another way so that we could talk to him. And I continued the same things when I became  
15 manager there as well. It took us 18 months before [ GRO-C ],- he sat down, and became  
16 a more communicative and vital person of our whānau at Whare Paia and Manawanui as  
17 part of that. But those are things that we did, were about people, were about people. So  
18 that's -- I've got, like Moe, we can talk about those forever.

19 But my last point is this: It's about our reo. It's about our reo. We have inherited  
20 some translated things from history. All of our discussions we had about the reo, about the  
21 land, about the whenua and belonging to it were recorded in longhand by somebody in the  
22 court. We're not lucky enough to have a (indicates stenographer) who can do it  
23 wonderfully now. But they all recorded it by longhand.

24 When we went back sometimes looking for some relationship, or some meaning to  
25 the land and whenua, we could see that sometimes the way they had written it had, instead  
26 of making one word -- sorry, making three words they made it into one. Karangahape is  
27 another example. It should be karanga-a-hape, it's three words. Karangahape tells you  
28 something else, but karanga-a-hape, that's another one.

29 Waitematā is another one, it's five words; te wai o Te Mata, the waters that belong  
30 to Te Mata. He named a lot of places around Auckland. I grew up here, they don't talk  
31 about the things when I was growing up here. For example, -tēnā koe Ngāti  
32 Whātua, --when they were putting that whare together up at Ōrākei, all the Māori in  
33 Auckland went, including my dad and whānau, all our whānau, we all went; we were all

1 part of it. When they put Te Puea together over at Onehunga, we all went. All the Māoris  
2 in Auckland, we all went.

3 So I don't hear them today talking about how they used to talk back then. They  
4 would talk about te wai o Te Mata, and I don't see them doing similar things, but you know,  
5 I do understand things change, but I don't hear the same whakapapa and the same links  
6 sometimes about those places.

7 But I do remember te Wai o Te Mata, five words, it's not one. The waters that  
8 belong to Te Mata. Te Mata named a lot of those places. When he died, ka mate te koroua,  
9 they put him on top of Rangitoto, kei runga tērā wāhi tiaki anō hoki nei te rerenga hoki nei  
10 o tōna moana (guardian of the sea that flows below).

11 So, our language, and consequently we've also become, we-- don't use our language  
12 now to tell us about what's happening. We've defaulted to a medical way of things, and our  
13 language tells us quite clearly about what's going on with us. It's a picture language. Do  
14 I talk about that later or shall I talk about it now?

15 **MS BAKER:** We're coming up to a short break, if you can keep it brief, three minutes.

16 **MR BAKER:** Two minutes; let's talk about the word pōrangi. It should be two words, pō rangi.

17 And it means the things you do during the day you're doing at night, the things you do at  
18 night you do in the day, so your world is upside down, okay? That's what happens, people  
19 are sleeping during the day and they're busy at night and they're upsetting everybody else,  
20 but your world upside down.

21 Ka huri ake nei to kaupapa ātaahuatanga (inaudible) waenganui i tō rā... So it's pō  
22 rangi, so that's what it means, upside down, --so you're busy. People take that to be mania.  
23 But what our tūpuna did was keep things normal. You still had to go and dig the kai, you  
24 still had to go and rukuhia mō ngā kai... do other things, so doing normal things helped to  
25 keep somebody online.

26 We understood that you can't keep going for 100 miles an hour all the time, so they  
27 kept them involved. And we had this little rongoā (medicine, elixir) - every iwi had rongoā  
28 that they used, okay? And it's important to understand that; important. For example, if you  
29 wanted to use the Kauri, you should come to Ngāpuhi. The Kauri doesn't grow in Ngāti  
30 Porou, the Kauri doesn't grow down in Tūhoe or Waikato, only grows from here north. So  
31 if you want to know a karakia about the Kauri and what it does, you need to come to  
32 Ngāpuhi. Don't come down to us. We'll tell you about Pohutukawa, we'll tell you about  
33 the Puriri, we'll tell you about the Te Ao Moana (to do with the ocean) and other things.  
34 But the Kauri belongs... Te Kauri belongs ki runga i a koutou...

1           So each iwi had a different part of the rongoā which went with it. So you need to  
2 understand some of those things; the karakia, the mihi and whakatau, all those things went  
3 with that. So we would go and see some things and sort sometime to give ourselves some  
4 rest in that period as well. And that's what we did. But people were still involved in life.

5           That's the main -- crucial. We didn't put them on a horse in the middle of Auckland  
6 and take them on a day's ride out to Carrington, chuck them there at the pleasure of the  
7 medical superintendent and then went back again. So we all had these ways of looking  
8 after ourselves, mahi pōrangī.

9           The other one, just one more; and it's the things my mother used to say, she used to  
10 take these little snippets. Tino rorirori anō hoki tēnā. You know just something's out of  
11 kilter with them, rorirori ana ... haere ana kia tīkina te tangata (inaudible) ki te kaukau (go  
12 and take it in the kitchen), bit upset about that, go and get them and put them in the kitchen.  
13 Just little things, how we might deal with situations of life, how things were upsetting  
14 things, but it was again --

15 **MS MILNE:** That balance.

16 **MR BAKER:** -- kept involved eh.

17 **MS MILNE:** Yeah. Before we stop for the break, Ronelle, I really want to just mention, because  
18 psychopaedic nursing was part of what I did, that the area for the disabled, intellectually  
19 disabled children in the day was one of the areas where tino tūkinō (abuse was rampant),  
20 and those kids were put into those institutions and then they got this bit of legislation that  
21 said nobody could actually go and get them or touch them. So at the deinstitutionalisation  
22 stage there were a lot of those kids with intellectual disability that got lost to their whānau,  
23 they just got lost, and that's another big area.

24           And I think that they're going to - I don't know if you guys are talking about it at  
25 some stage later on, but the whole kaupapa of kids with disabilities, intellectual disability,  
26 and even now we still can't get it right. But that was the area where quite a lot of -tūkinō  
27 (abuse) happened because they couldn't talk, they were physically disabled, they're  
28 mentally disabled and they're intellectually disabled. And people don't talk a lot about  
29 them, but I think that's a group, -they made a big institution at Carrington, down by the  
30 forensic services that were supposed to be for 30 adults with intellectual disability who  
31 possibly were violent and- check out the Māori numbers in there even now, and that  
32 institution is now up to about 100.

33 **MR BAKER:** Yeah.



1 **MS MILNE:** So I just want to make sure we don't forget about that group of people as well.

2 Kia ora.

3 **MS BAKER:** Kia ora, tēnā kōrua, thank you. Nō reira, tēnā tātou katoa. We are now going to  
4 move to a short break, we will return to the livestreaming event, I'll call it at 11.30, so we  
5 will take just over 20 minutes, whānau.

6 So if you would like to rejoin us on the livestreaming event at 11.30 am, we will be  
7 reconvening and talking about intersectionality. And we will begin with Tristram talking  
8 about intersectionality, and then at the closing portion of our session, we will be talking  
9 about what the future might look like and how we can build on the whakaaro that has been  
10 shared today. Thank you everyone for your time, we will now adjourn.

11 **COMMISSIONER GIBSON:** Kia ora, thank you Ronelle. And just a message from our Chair,  
12 Commissioner Shaw, who is unwell today; she battled until the end of the day yesterday but  
13 is watching from home at the moment. Kia ora, thank you.

14 **Adjournment from 11.08 am to 11.37 am**

15 **COMMISSIONER GIBSON:** Kia ora, everyone, welcome back. Just a reminder for those who  
16 are not socially distanced to wear masks. And there are some people who are exempt from  
17 wearing masks and some people are vulnerable so keep that in mind.

18 Kia ora, back to you, Ronelle.

19 **MS BAKER:** Tēnā koe, Commissioner Gibson, thank you for reconvening us after our break and  
20 nau mai haere mai ano, welcome back to the people who are joining us on the livestream.  
21 For those of you who don't you know, my name is Ronelle Baker, and I am facilitating the  
22 panel and I am privileged now to start this part of the session off with a conversation about  
23 a concept that we call intersectionality.

24 So, I'd like to first invite you, Tristram, to talk to us a bit more, you talked earlier  
25 about the evidence, about inequities for Māori and we know that evidence shows Māori  
26 have higher rates of disability, are more likely to experience mental distress than  
27 non--Māori. If we consider the factors that may lead to an increased risk of abuse, how  
28 important do you think it is for the Royal Commission to interrogate the intersection  
29 between racism and ableism?

30 **DR INGHAM:** Tēnā koe, Tristram Ingham speaking here again. I guess in answering that pātai,  
31 I guess I would -- I just want to focus on the component of your question, considering  
32 factors that may lead to an increased risk of abuse. To me, I think the evidence that this  
33 hearing has heard and even reinforced today, we need to question a couple of fundamental  
34 aspects.

1           We talk about abuse as though it was an aberration from the norm. We talk about  
2 abuse as though it was an individual or a misuse of a system as it was designed. I put the  
3 hypothesis, actually, that the system as a whole has performed as designed, as intended.  
4 The system itself was set up to be a form of abuse, and it may have been put in the guise of  
5 care as a hospital, as a therapeutic service, but the system itself was the abuse.

6           I think the other thing that we talk about is care. I would put the hypothesis to you,  
7 we've taken an assumption of good intent throughout this Inquiry where  
8 we've -and- through Wai 2575 as well, where we assume the fundamental intent was care  
9 and therapeutics.

10           I think the evidence that you will have heard through this tribunal calls us to require  
11 to refocus that hypothesis, that if the system, its primary purpose was not care but  
12 detention, incarceration, how then would the system have looked, have acted and responded  
13 to the factors that we've seen.

14           And I think we heard kōrero from Ron and Moe earlier in the session about how  
15 there were superintendents who were, I think the quote was, "like Gods" in the sense.  
16 There was often no therapeutic intent being conveyed in these institutions. And you can  
17 tell that by looking at how often therapeutic interventions or even engagements were being  
18 made. Sometimes people only had clinical input on an annual basis. And I guess the  
19 question if you were taking a view of what would be the pastoral care, or habeas corpus  
20 requirements of a detention facility, they would not be too dissimilar.

21           So, I guess that's -the first thing to say is that this whole inquiry needs to focus on  
22 the fact is that there are forms of oppression and there are tools of oppression that the State  
23 has used, continues to use, and it's really important that we identify those as a system, - and  
24 we recognise the roots of that. Abuse will always occur in a system where there are  
25 imbalances of power, both creating those systems, maintaining those systems, and within  
26 those systems.

27           So, I think intersectionality and the concept of that is an important analytical tool  
28 for the Commission to understand the multiplicative impacts that occur as a result of forms  
29 of oppression, not just one form of oppression, but actually multiple. There are oppressions  
30 such as colonialism, imperialism, racism, ableism, patriarchy, classism, xenophobia,  
31 homophobia, transphobia, and religious discrimination, all impacting simultaneously on  
32 this population and there are power bases for each of these that serve to try and protect the  
33 status quo.

1           Now, I guess intersectionality can be shown in multiple ways. One example would  
2 be around data monitoring. There are almost no statistics and certainly no systematic  
3 administrative statistics that collect disability status and ethnicity in a way that allows them  
4 to identify both. There are cross-sectional- surveys of one or other, but -so, Statistics  
5 New Zealand, for example, in their survey Te- Kupenga, it is done five years' offset, that's  
6 the Māori survey, it's done five years' offset from the disability survey, ostensibly under a  
7 cost cutting- measure. That means there is never a simultaneous assessment of the Māori  
8 view and the disability view. That's an example of how intersectional disadvantage can be  
9 baked into a system.

10           When you think about what really impacts pae ora, health and well-being of  
11 whānau, it is a life course event. There are multiple points in the chain at which  
12 disadvantage and where oppression in its multiple forms can occur.

13           Camara Jones, in her research on inequity, speaks about three broad areas in which  
14 inequity can occur within health and disability systems.

15           Firstly, inequity can occur in inequitable access to the determinants of health,  
16 whether that be education, housing, employment, justice. Inequitable access to and through  
17 health and disability care. So getting into the system, having access to preventative care  
18 and care close to home.

19           The third aspect is a differential quality of care received. And that is perpetuated, in  
20 particular, by culturally unsafe models imposed on tāngata whaikaha Māori and Māori  
21 experiences of institutional racism and explicit and implicit racism within services.

22           So I want to say that I presented those three levels there, but they are not linear, they  
23 are not one leads to another. They are cyclical and compounding. So I think that's a really  
24 critical element to consider, that if an institution that has --the role of State care does not  
25 empower whānau, community and individuals to be in any way self-reliant or -self-  
26 sustaining-, it breeds a dependence, and that dependence becomes like a positive feedback  
27 loop that requires further State intervention, further State dependence and therefore a  
28 greater risk of being subject to conformity, as we've heard, with State requirements, and  
29 dependence on actors within the system.

30           There was very little opportunity within institutional care frameworks for people to  
31 be better off at the end of that care experience than they were beforehand. To come out  
32 with skills, vocational opportunities, that have been educated, to have gained experience in  
33 tikanga, te reo, these things were not part of a therapeutic process. These were primarily  
34 facilities of detention and isolation.

1           And I have to say that those institutions, despite previous reports and Royal  
2 Commissions, have not gone. Those institutions are still there today, very much in power.  
3 The bricks and mortar may have gone, as we've heard described, but the institutions, ie the  
4 power structures still exist today.

5           And one thing that I've really seen is that the system, these power structures, are  
6 uniquely responsive to changing the rhetoric, changing the guise, changing the way  
7 that-- they appear to be responsive while fundamentally not changing the differential in  
8 power dynamic control.

9           You can see, when you just look at, just take some off the cuff examples. The fact  
10 that Te Tiriti o Waitangi and the Waitangi Tribunal is nonbinding on the Crown and the  
11 fact that there are no recognised and resourced tāngata whaikaha Māori nationally  
12 mandated groups to speak for, on behalf of tāngata whaikaha Māori. There is no  
13 mechanism within either the UNCRPD or UNDRIP for the intersectionality of tāngata  
14 whaikaha Māori.

15           The only mention of indigenous people in the UN Convention on the Rights of  
16 Persons with a Disability is in preamble P and in the UN Declaration on the Rights of  
17 Indigenous Peoples, disability is barely mentioned at all.

18           So even in our international covenants there is very little protection for that  
19 intersectional space.

20           I'll leave my comments there, but I think -- what I think is really important to  
21 recognise again in summary is that these systems in my view have operated as they were  
22 intended, that the oppression, I've seen nothing, even to the present hour of the present day,  
23 that gives me any confidence that the power basis has shifted or that there is a genuine  
24 willingness to partner with tāngata whaikaha Māori communities, tāngata whaiora  
25 communities to actually lead the development or change in this space. Kia ora.

26 **MS BAKER:** Kia ora, Tristram, thank you. Before we come to you, Karen, I'd just like to  
27 actually invite the panel to comment on the whakaaro that Tristram has just shared. Gary,  
28 I'm hearing some things that are consistent with what you talked about earlier in terms of  
29 the system maintaining itself and justifying its own existence through the maintenance of  
30 keeping people institutionalised. In hearing Tristram's kōrero, is there anything further  
31 you'd like to add?

32 **MR WILLIAMS:** I want to go back to Ron about language, because I know that we talk about  
33 the Care and Protection system, but I think that's a misnomer. It's never been about care,  
34 and it's never been about protection of the people, or the people it's supposed to serve, it's

1 about care of keeping a system going, so that the system can feed itself with people who  
2 might not benefit from any interaction with (inaudible). Yes, I agree with everything that  
3 Tristram says. He says it in a very eloquent way, you know, because I would have trouble  
4 explaining in a couple of short sentences.

5 **MS BAKER:** Moe and Ron, what are your thoughts having heard that? Would you agree there's  
6 not a lot of therapeutic intent in the system, that it was sort of set up under the guise of  
7 being therapeutic but actually didn't benefit people?

8 **MS MILNE:** Yeah, I just want to say, Tristram, that one of the things that I ponder right now is,  
9 and we started this with people saying that, you know, we adhere to the principles of Te  
10 Tiriti o Waitangi, and there are two parts of Te Tiriti o Waitangi that are never, ever  
11 discussed with their full intent. The first one is the statement of intent which actually  
12 clearly describes what the relationship is and what the relationships of mana are. And it  
13 didn't say or describe anything other than the Crown and the hapū or Nu Tireni, that's the  
14 first part.

15 The second part, which I actually totally agree with what both these guys are saying,  
16 is that at the moment in Health and Disability services, everybody's talking about equity,  
17 everybody's got an equity statement. And I go, "Excuse me, people, you said we're going  
18 to operate under the auspices of Te Tiriti o Waitangi." Article 3 in Te Tiriti o Waitangi is  
19 about equity.

20 So, if we're going to be, so- I get fearful, when we're having these kind of  
21 conversations- that we just put another layer and another layer and another layer of non-  
22 action on something, so we've got a Treaty of Waitangi statement, but we don't actually  
23 enact- the equity part of the Treaty of Waitangi. We've got a Treaty of Waitangi statement  
24 and we don't talk about what the relationships or the power of the partnerships are of Te  
25 Tiriti o Waitangi. So just tautoko i ngā korero (support what's been said).

26 **MR BAKER:** Yeah, you're right.

27 Kia ora, Tristram, tautoko ana i tō korero (support what's been said). I've just got  
28 two things I want to say. One, I remember the big fights we had in the Ministry of Health  
29 with George Salmond when he was the Director General of Mental Health, and we  
30 managed to get the Treaty of Waitangi included in the health contracts. What a hell of a  
31 fight we had. And the only reason we managed to do that, because Paratene Ngata, Mason  
32 Durie and that fulla Raukiri(?) from Taranaki were part of the Public Health structure down  
33 there, and the overall person, that was John Macleod.

1           John McLeod became the Chief Medical Officer of Auckland, but he was the major  
2 influence, he was the Chief Medical Officer, part of that Public Health group, and we  
3 managed by sheer force of scraps and hui and all sorts of things over two or three years to  
4 get the Treaty included in the health contracts. That's way back in 1985, 6, somewhere  
5 around that time.

6           We had these huge, big rows in Wellington. We got them included in the mental  
7 health contracts and then John McLeod shifted to include a statement into the health  
8 contracts, and they were renewed then.

9           And it is from that we've managed slowly but surely to include more and more of  
10 the Treaty. It never -- it was never enough. It was never enough. But we then came to,  
11 rather than fighting in a place where we couldn't get a major result, we came down to  
12 another strata and we started to fight more and more often at the care level, where we had  
13 more people in and more control over what we could do and how we could do it.

14           We got lots of casualties from that as a result, but it comes back, --two lessons we  
15 learned from the Māori Battalion. I--f you want to do something different, re-organise what  
16 you've got. That's what you can control, that's what you can develop. That's what our  
17 fathers and uncles and grandfathers did, when had --when they lost, they re-organised  
18 themselves to go to different problems and present different problems they did it  
19 themselves. Then they impacted that on the system, and that's what we did; with such  
20 things like Waioira, Whare Paia, Manawanui, Rapuora down in Kingseat and all of those  
21 things, and Whare Marie, and we developed -- we came to a place, a space which we had  
22 more control over, and we could do more things with and left the other battle for another  
23 time. But it's never gone away.

24           But you're right, Tristram, the system is impacted upon itself. And it did the same  
25 thing. Instead of delivering care, it became risk averse, and developed a whole risk side of  
26 things, became culturally averse, and the only culture they developed was about care.  
27 When Moe and I trained in our nursing things we had a DSM 3, they've now got a DSM 5,  
28 which has got another 300 more pages of diseases which you and I, all of a sudden,  
29 contracted. Another 300 pages. Where did that come from? That came from somebody's  
30 brains from somewhere else. But you and I now suffer from another 300 pages of disease  
31 from that DSM 5, which we never had before, we never had before.

32           So that whole system impacts upon itself, becomes culturally averse and then  
33 becomes more clinically responsive, and then, like just what Tristram was talking about,  
34 and then making itself responsible for us, and such things as appointing an equity manager.

1           What the hell's that? Who the hell knows? It'd be much more important if they appointed a  
2           Ngāti Porou person in Tainui or a Ngāti Porou somewhere else. That would be good, eh?  
3           We've got some in there, we have got some in there.

4   **MS BAKER:** Kia ora, thank you, we won't follow through with that recommendation, I don't  
5           think they'll be appointing Ngāti Porou specific roles any time soon in other hapū, but thank  
6           you.

7   **MR BAKER:** Can I tell one of my jokes?

8   **MS BAKER:** No time for jokes, we're going to move through to Karen, thank you, panelists.

9           Karen, we'd like to hear your views on racism and abuse. Specifically, do you think  
10          that a Māori Deaf person is at higher risk of abuse than a Deaf person who's non--Māori,  
11          for example?

12 **MS POINTON:** Firstly, I'd just like to acknowledge Tristram, and I agree with you. I think that  
13          what you've said about this comes into what I'm about to say about abuse, that it's the  
14          system. The system of inequity really.

15          And that's based on whether it's misogyny or whether it's racism, all of those things  
16          come into inequity. And different class systems, whether you are poor or wealthy, all of  
17          these things flow into abuse.

18          Also, the other things linked to discrimination and oppression, is the  
19          intersectionality for the individual. And I think intersectionality really helps you if you  
20          understand that concept, that helps you understand those individuals, and how that  
21          oppression has been impacted on them. That discrimination happens and it's come from the  
22          system and created by the barriers that the system has created. And tāngata Turi definitely  
23          have experienced that.

24          So tāngata Turi have definitely experienced racist abuse. Because they've been  
25          within a Pākehā system. And why do I say that? I say this because -- let me give you an  
26          example. So there's different protocols and policies from different Government  
27          departments. They don't understand about tāngata Turi and how that connects in with the  
28          system and so they have a unique kind of discrimination and set of barriers that occurs for  
29          them like, for example, sign language interpreters that speak te reo, that are raised speaking  
30          te reo, that are Māori, and so that Māori Deaf can be included in education to express  
31          themselves equally. And that's not the same for Pākehā Deaf. You know, so there is an  
32          inequality there and there is an experience which is less.

33          And, of course, as I said before, there's not enough Māori teachers, there's not  
34          enough Māori staff, so tāngata Turi students don't have that bond and that ability to connect

1 with those staff, you know, and to create that situation which creates more equity. And this  
2 is still happening, in my view. My colleagues who are Māori, their view also is that it's still  
3 there, this abuse is there, still.

4 We need to change this attitude; we need to change this culture. We need to have a  
5 positive for our Māori Deaf students and create situations where they can be included in  
6 their schooling system without feeling that cultural oppression. Because the system  
7 controls this inequality, and all of those things that I've said creates that oppression and  
8 discrimination. And this is the proof, it's shown, it's happening still now, and it has been  
9 going on forever, and it is still there today, that racism.

10 And the pathway of tāngata Turi I feel is not progressing forward because of this.  
11 We need to make sure Te Ao Māori is the centre of this with Māori staff so that our tāngata  
12 Turi students can connect.

13 **MS BAKER:** Tēnā koe, Karen, thank you so much. I mean, we're obviously starting to talk about  
14 our vision for the future and how are we going to change things. Tristram, you've talked a  
15 lot about the entrenched power imbalances and while there's some glossing and shifting of  
16 narrative that some of those inherent power imbalances still exist, a lack of understanding  
17 and acknowledgment of Te Tiriti in practice and how we're actually, -I guess when we talk  
18 about partnership, you make an assumption that the partners come to the table with equal  
19 resourcing and power, and we know that's not the case, because of the systemic, -long-  
20 term- cyclical oppression of Māori.

21 So I'm going to first come to Ron. So you've been involved in setting up services  
22 that have reflected mātauranga Māori, offered a more holistic model of care, some of those  
23 services were funded within a DHB structure. In your view, what are the critical success  
24 factors for achieving this kind of service? What suggestions do you have?

25 **MR BAKER:** I've got four. The first one is, yes, I've been lucky enough in my work journey to  
26 be part of, I think five, five kaupapa Māori services from the start. And for each one they  
27 were not a job I applied for. Someone from that iwi came to see me and asked me to be  
28 part of it, starting with whaiora in Tokanui when the kaumātua from Maniapoto came to see  
29 me to be part of the first of these kaupapa Māori services.

30 When I came to Auckland, the kaumātua from Ngāti Whātua came to see me. For  
31 my sins, I was the second person appointed to the forensic services in Auckland, after  
32 David Chaplain(?), one week after David Chaplain, I was appointed, part of the way the  
33 cultural services are in Mason Clinic as part of the plans that -- I was the second person



1 appointed to the forensic. I was there for seven weeks, the kaumatua came to see me and  
2 I became the last manager of Whare Paia, and then developed from that Manawanui.

3 Rua Cooper from Tainui came to see me as well and I went down to Kingseat for a  
4 month and a half and put the cultural services in place down there. And also, the kaumatua  
5 from home -when I became the manager of the community services in Gisborne, and  
6 also- back home in Mahia. Because I just happened to be around the area.

7 But all of these services I've been part of I was asked by the iwi to come and be part  
8 of it. They're not jobs I applied for.

9 The second thing is that that places a different responsibility on you, it's that you  
10 then are not part of developing the services for -- it's part of developing the services for  
11 your people, for the future, and for the (inaudible) that you're in, which requires then a  
12 different way of looking at things.

13 How do you provide a service? Well, let's take here in Auckland, and we were the  
14 luckiest people on earth at that time, e mihi ana tēnei ki a koe i tō whanaunga John McLeod  
15 (who I acknowledge your relation, John McLeod).

16 **MS MILNE:** Yeah.

17 **MR BAKER:** We had the most senior public health medical person in the country, was here, in  
18 part of Auckland DHB. The Ministry, or the Ministry of Health would not do nothing  
19 unless they spoke to him, he was the most senior person, John McLeod, and nō Ngāti Hine  
20 hoki nei tēnei koroua (and he's from Ngāti Hine), and when he died things changed quite  
21 drastically.

22 But the second part of the kaupapa is that you have to get control of the service, you  
23 have to understand the business that you're in, and often people don't understand the  
24 business we're in. What's the business of mental health? Kaupapa Māori. What's the  
25 business? The business is about having control of people coming into the service, getting  
26 some care, and then going back to the whānau, so it's like a cycle.

27 What's the part that gives you control of people entering? It's the legal one. It  
28 requires you to have access under the law to be a gazetted place of entry. If you are not a  
29 gazetted place of entry, you have to go to the main hospital. You come through the  
30 admission ward and when they've finished mucking around with you and putting you under  
31 the Act and all sorts of things then they come over here to you. So you need to get hold of  
32 the port of entry.

33 Manawanui was the only other place in the country that became a gazetted entry  
34 place for people under the Mental Health Act or under any Act in the country and required

1 people like John McLeod and the board to agree to get that done. Because it requires an  
2 Act of Parliament to do that, a supplementary part of the Ministry has to approve all those  
3 sorts of things.

4 So we managed to do that. So that gave us absolute control of entry, we could then  
5 give a diagnosis or say what's wrong with our whānau and deliver some cultural care to  
6 that, which is what we did. And we were lucky enough at Manawanui that we had,  
7 I thought he was the best kaumatua in Ngāti Whātua, (inaudible) at the time, after te  
8 matenga hoki nei o Henry Sutherland (after Henare Sutherland passed) who in his time was  
9 the, I thought the biggest -- the number one kaumatua in Ngāti Whātua as well. That -- it  
10 became linked to the kaupapa and to the tikanga that belonged here in Auckland. That was  
11 a part of care of delivery.

12 If you took a -- we did everything in our whare tūpuna. If you came to one of our  
13 clinical review meetings -- we had them twice a week -- there would be 100 people in the  
14 room, and everybody had a say. Pēna mai hoki tō tātou nei kaupapa waihotia tō tātou nei  
15 tūpuna ki a tātou haere koe ki rō whare, tū mai he hui i reira, tū mai te korero. (That's how  
16 it is, our ancestors left it for us to organise those. If you came into the house everyone had  
17 a say).

18 Everybody who came had a say. So it was not about isolating that the doctor, the  
19 tākuta (doctor) only had one say, his say, everybody else had a say too. But it came down  
20 to the the kaumātua pēnā nei e takoto pai hoki nei te kōrero te kaupapa mō tātou kia awhi,  
21 mai tautoko mai tēnā. (The elders would lay down what the issue was). And when we  
22 admitted somebody under the Mental Health Act, we admitted the whole whānau. So not  
23 only did you come, you came with your whānau too, and we admitted three, four, five  
24 people. Sometimes we had 10. Everybody came, noho mai ki rō te whare (they all came to  
25 sit inside the house).

26 And we had other places as part of that too. We had a respite for women, we had a  
27 Kōhanga Reo, 30 kids, if you brought the kids, they all went to the Kōhanga Reo as well.  
28 We had a Kōhanga Reo, all part of this whole community part, and the residential things, so  
29 it became a whole service entirety in itself.

30 We got to a stage where we really didn't need the DHB, we had our own funding,  
31 and that's part of understanding the business, is a cultural thing.

32 The other thing is one is to understand the business of management. And we don't  
33 have enough people that do that as well. I was lucky enough that I went and did  
34 some -- you couldn't become a charge nurse or any nurse above a staff nurse in our time

1 unless you went and did an advanced diploma in nursing, I've got an advanced diploma and  
2 other nursing stuff as well, which gave you more ways of looking at managing and  
3 structure, not only staff but pūtea and how to develop it and how to organise that.

4 As part of the devolving, the deinstitutionalisation stuff, every hospital like  
5 Kingseat, and Tokanui and where you were down in Ngawhatu, they were regional places.  
6 So for example if you got unwell in Kaitaia they brought you from Kaitaia to Carrington.  
7 One of the wards was part of that. West Auckland, central Auckland, all those things.

8 When they closed them, I demanded the cultural, the Māori budget from each one.  
9 And I came with -- and they said, "How much is that?" I said, "It is 5% of the total  
10 budget." So they gave it to me, and I spent it, all on staff. Because we were -- people don't  
11 understand the business. If you're a gazetted place, you're also tied by law under the -- to  
12 the DHB or to the governing body for them to provide you care and enough staff to deliver  
13 care. It's a -- it's in the health constitution stuff. So once we became gazetted I had all  
14 these other (inaudible) to pay.

15 So we just went from \$800,000 to a \$2.9 million in a matter of about eight weeks.  
16 Wonderful. In ten weeks, I'd spent the lot, all on staff.

17 So it's about how you conceptually use these things and how you understand the  
18 systems of that. We don't have enough people that know that at this point in time, we're  
19 putting too many green people in the places of (inaudible). But that grew the system until  
20 eventually we did not need the DHB at all because all our staff was all in one part.

21 And for my sins, every time I become a manager or a CEO, people want to sack me.  
22 No-one's had the sack as many times as me, I'm a registered nurse, I've had the sack six  
23 times, five of them when I was the manager at Manawanui. Every time they want to  
24 change something, I'm in the road. I had a \$40,000 kai budget. How many services here  
25 have got a kai budget of \$40,000? In 1992 that was a huge budget. 40 grand. Fed  
26 everybody, fed all our things. We had, like I said, 100 people, if you come to one of our  
27 celebrations, you might get 250 people. We'd feed them all.

28 Huge structure, huge amounts of growth and development. Anyway. When Service  
29 changes, they want to do something else, I'm in the road, so I knew I was in the road, and  
30 when John McLeod died, that was -- it gave them an access which they never had before.  
31 So kia ora, that was just one of them.

32 But it's about understanding the business you're in, understanding the kaupapa, and  
33 the way that cultural systems and functions work, and sometimes you only find that out  
34 when you sit on the paepae (where the orators sit), if you go to a hui, you need some

1 experience about how to structure those things, and understand that and how to understand  
2 and how to be responsible to the whānau and to the iwi that you're there, you're accountable  
3 for these things.

4 If something happens in the Service the person responsible is you, the one at the  
5 top, not the one in the middle, the one at the top. You either did not provide enough  
6 programmes for them to get enough skill to deliver the care or you did not provide enough  
7 resources. So the person who carries the can is you, the one at the top. That's happened to  
8 me four times, and I've lost somebody to suicide and stuff.

9 **MS BAKER:** Kia ora, Ron, I apologise for jumping in there, we're just running short of time, and  
10 I want to allow our panelists some time to talk about the future.

11 So, Moe, just briefly, can we come to you to talk about what kind of delivery  
12 models are needed for the future and the workforce needed to deliver, and then we'll come  
13 to Gary.

14 **MS MILNE:** And what Ron's just described is absolutely the model that happens all the time, as  
15 soon as we become successful in delivering a service and certainly out of Manawanui, and  
16 what he doesn't describe, because some of that is actually, we think it's ordinary. The  
17 tāngata whai (inaudible) rā and their whānau were part of the development of the service,  
18 and because they were -- and so when you go to Manawanui to the whare hui, often the  
19 people who are doing the -- taking care of the pōwhiri and all that sort of thing are also the  
20 users of the service. So some of that was built in.

21 The thing that needs to be -- when we're talking about the future and what are the  
22 solutions for the future, is that there have been several, several Māori models and I do still  
23 have a little bit of awangawanga or concern about what's happening now with the new kind  
24 of Health and Disability systems in that they say, "You can't do this, you can't do that, you  
25 can't do that," but who has power and control at the end? Actually, it's not us, even at the  
26 higher echelons of things.

27 So one of the ways to make the changes, all the things happen, is that there has to be  
28 a commitment, a commitment -- hang on, I want to go back because I want to talk about  
29 abuse in it's -- just to have a little description of this in around -- this Commission is about,  
30 you know, looking at abuse in care and what care is that, which care, and as Gary  
31 challenged, is that the right word anyway. Because there are two types of abuse that  
32 actually happen to us, and the first one, let's talk about the systemic abuse. The systemic  
33 abuse then enables personal abuse to happen. The systemic abuse allows for abuse that is  
34 deliberate and so that you have people who have been incarcerated, and I'm talking the

1 whole gambit of whaikaha now, whether you're mental, emotional, all the different types of  
2 disabilities, because somebody else has been deliberate about saying, "This group of people  
3 don't fit our systems."

4 About three or four years ago, I actually wrote the intersectoral policy or tried to  
5 write the intersectoral policy on addressing abuse and I named colonisation, and I named  
6 racism as an abuse of people, this was primarily to look at women's safety from abuse. And  
7 cross-party political parties took it out, it didn't go anywhere, that policy didn't even survive  
8 a second or third kind of iteration, because the Crown will not actually accept their role in  
9 being deliberate, i.e., using colonising systemic abuse, on us as a people, that's the first part.

10 Because what then has to happen is then they need to be recognised that having  
11 systemic abusive policies and kaupapa allows personal abuse to happen, because then it's  
12 actually your fault, it's actually your fault if you get taken away because you didn't behave  
13 yourself and conform to the system.

14 And so to make the changes, or what needs to happen to get us past this part of our  
15 histories, is that there has to be an absolute Government commitment or Crown  
16 commitment and willingness to the long term. We plan and we do all this stuff that we do  
17 because we can see our grandchildren's grandchildren being the next group of people that  
18 take control of what's happening. We're planning like that. We have to start getting  
19 commitments for long term so that we don't ever -- you see, Manawanui at the moment, we  
20 still use it, Manawanui, we still use it and it's not to the extent that it was planned. And all  
21 these other little things that we're doing.

22 So that's the big picture stuff. There has to be an absolute willingness to the  
23 ongoing commitment to making changes, but also to the ongoing ability of Māori to  
24 provide the solutions for Māori issues. And that requires resource, that requires extra  
25 training, and that requires people to get out of the road when they don't understand what it  
26 is you're doing, because we understand what we're doing. And I think, you know, because  
27 again, I'm one of the people -- I go around the motu (whole of the nation, country), I go and  
28 train brain researchers, I go and train nurses, I train anybody who wants to know what  
29 cultural best practice is and I go around the motu doing this.

30 And the change is minimal and that is to persuade individuals that the systemic  
31 change is dependent on the individual change, I'm a bit Gandhi-like in that respect, but to  
32 actually persuade people that you have to take a stance, and one of the -- I was talking to a  
33 lady out there while I was having a cup of tea, the other thing, we talked about deliberate  
34 abuse, but we actually don't often talk about abuse by omission, by nobody taking action,

1 by nobody saying, "That's not okay to have our people disenfranchised or taken away from  
2 their families."

3 So I can give you good pictures of great training programmes that we write, but  
4 actually we all have to take some, not responsibility, but make a stand against the constant  
5 systemic abuse of us as a people in our land. So kia ora.

6 **MS BAKER:** Kia ora --

7 **MR BAKER:** Can I just add one little piece to that, please? Just one piece, thank you. When we  
8 closed -- when they closed down Tokanui they invited all the different iwi from over home  
9 all the way to Taranaki, haere mai ki te whakawātea te whare. We did all those things, and  
10 then we got to the back and at the back of Tokanui there is this big urupā (graveyard), with  
11 all these unmarked graves in them, and a lot of them come from koutou ngā iwi whaikaha  
12 (disability people) and there was unmarked, unknown, and also there were -- some of the  
13 products were some -- results of some inappropriate relationships had by some people who  
14 could not speak for themselves. And the results of that were --

15 **MS MILNE:** (Inaudible).

16 **MR BAKER:** Yeah, some born -- some kids were born -- in Auckland, over here in Carrington,  
17 they took them and buried them in the Avondale cemetery. The original part of this was  
18 called the Whau Mental Institution, which is based around our people living on the Whau  
19 River, which is just the big one on the other side. They had a little park at the side and  
20 anybody who had someone who died in that was taken and buried there, in the  
21 Avondale -- they call it in the Avondale cemetery now, at the back there.

22 But there's a lot of people who were part of that abuse that happened in care and  
23 they took them, nothing was happened, everything was swept under the table, or at the  
24 pleasure of the medical superintendent, back then they were closer -- they were more than  
25 God. And it wasn't until we got a few more investigations that some of these things came  
26 out.

27 The last one, I just want to say that those two young fullas from Ngāti Whātua who  
28 died as a result and they closed down Oakley, one of them, they came and saw me because  
29 they kept one of the hearts, the heart -- because it was enlarged, more enlarged than the  
30 other, and they did some research on it. And wasn't until John thing came up from  
31 Taranaki and did his inquiry, five days in, that they brought up the heart that they had taken  
32 and kept by themselves as a result of they wanted to do some more investigations in a  
33 laboratory about the effects of the medication, the effects of all this on this person. And  
34 then they brought the heart over to Whare Paia and asked me to take it back.

1           How do you take something back to an iwi when they've already had a tangi? Take  
2 bits and pieces of the body back? Tough stuff to do. You couldn't find anybody at the  
3 DHB for a week after that. Māku hoki e whakahoki atu ināianei tērā ki runga hoki o  
4 Orākei, tangi ai, tangi ai. (It was for me to return that back, return it to these people of  
5 Ōrākei). But they asked a Māori face to represent them to a Māori face for part of the  
6 intrusions and part of the things that they've done as part of -- as they saw the real care(?).

7           And that's been an ongoing thing and the only reason we've done it, and I know  
8 Moe's done some -- the only reason we've done it. Tō tātou nei aroha ki tō tātou nei  
9 whānau... (we do it for our love for our family, for our people). That's the only reason  
10 we've done it. They're not that easy things to do. But our system is full of such events.

11 **MS BAKER:** Kia ora, thank you. That is a reminder of the depth of pain and the long-term  
12 impact for whānau, hapū and iwi. I am aware it is 12.30. I just want to do a check in with  
13 our Commissioners, we are nearing lunch, I think in terms of our panel we'd be Hape to  
14 continue for another 15 minutes just to allow Gary, Tristram and yourselves to -- and Karen  
15 to make any closing remarks. Would that be okay on your part?

16 **COMMISSIONER GIBSON:** Yes, I think we'll try and keep it tight to the 15.

17 **MS BAKER:** Thank you, Commissioner Gibson, appreciate that. Gary, we'd like to now invite  
18 you, you talked about having your fingerprints on Enabling Good Lives. Tell us more  
19 about your vision for the future.

20 **MR WILLIAMS:** So what I think it's going to be 2024 before any recommendations get  
21 implemented, so we've got under one and a half years to get this right. So I'd like to think  
22 that we wouldn't reinvent systems that don't work. I think that we need to get smarter  
23 people at the table to talk about what will work, because we -often - we enter into  
24 discussions in good faith that the people we are talking want the same kinds of outcomes  
25 that we want, but often we talk at cross, we talk at -cross-purposes- and what we said we've  
26 agreed to is not what's been agreed to after.

27           So I would like to see survivors be at the table to talk about, in more detail, about  
28 what good outcomes could be for us, because our voices are often the last voices that get  
29 heard and our voices often are discredited by people who think they don't have an  
30 experience. That's what I'd like to see, because I don't want to talk about the care system  
31 anymore, because I'm not sure that it ever was a care system and I'm not sure if it can be a  
32 care system.

33           So let's get the language right so that we all know what we're talking about and what  
34 we want to achieve.

1 **MS BAKER:** Kia Ora, Gary. So getting the language right, having survivors at the table, talking  
2 in detail about the outcomes they want to see, and having the power over shaping those.

3 **MR WILLIAMS:** So that we won't be disappointed for another decade.

4 **MS BAKER:** Let's not do this for another decade. Ae, ki a koe. (I agree with you).

5 I am going to come to Karen then to Tristram then to our Commissioners. So  
6 Karen, tell us about your recommendations for the future for Deaf Education.

7 **MS POINTON:** I've talked with my other colleagues about recommendations for Deaf Education.  
8 I think we really need to review the curriculum. Also, we need to include Te Ao Māori and  
9 te reo Māori and also in a practical way. So the policy says that they will deliver, you  
10 know, Māori in a practical way, but that's just hearsay. We need to make sure that this is  
11 happening, so from the Ministry of Health, the Ministry of Education, Ministry of Social  
12 Development, yeah, and also the legal system, that this is really being acknowledged.

13 So this recommendation is to make sure that we have access to the Crown for  
14 funding, to the Tribunal and the Commission to create opportunities for all of us, all of us  
15 tāngata Turi to have the resources available for us, so resources like -- so that we can access  
16 education and in an ongoing basis, and that we can create this ongoing relationship, and  
17 partnership and with trilingual interpreters. And the teachers that have the skills, that know  
18 sign language well, we don't have that at the moment.

19 We really need to reinforce the Sign Language Act of 2006, that it's as a priority in  
20 schools. And we need to make that commitment and obligation to make sure that those  
21 recommendations are, that they're actually doing it and it's not lip service.

22 So the Sign Language Act 2006 was put forward for the legal department that in  
23 legal settings it must follow the Act, so the recommendation would be that this include  
24 Deaf Education as well. So this needs to improve and this needs to change, and we just  
25 need to provide more Māori staff and the opportunities for Māori Deaf staff to be involved  
26 as role models for our tāngata Turi students.

27 That's the recommendation that I'd like to strongly put forward to Government, to  
28 make sure that they realise it's about resourcing. Thank you. Kia ora.

29 **MS BAKER:** Thank you. We now turn to you, Tristram, for your final remarks before we head to  
30 the Commissioners.

31 **DR INGHAM:** Kia ora. I have much more to say than this session will actually allow. I guess I  
32 reflect on the opportunities that this session has given and to say that those alone are not  
33 adequate to address these issues. I think in terms of reflecting on the future, we need firstly  
34 an improved service oversight monitoring and safeguarding processes. None of the



1 existing processes for service oversight monitoring and safeguarding are sufficiently robust,  
2 all-encompassing, or with sufficient teeth to provide timely and appropriate safeguarding  
3 for tāngata whaikaha Māori.

4 I think that is going to require a legislative review, not only of the Human Rights  
5 Act but other things such as the Code of Consumers Rights and other legislation as well,  
6 legislation that would actually enshrine Te Tiriti o Waitangi in a domesticated way, that  
7 would actually domesticate the obligations of the UNCRPD and UNDRIP, neither of which  
8 are binding currently.

9 I think a critical element of the service oversight monitoring and safeguarding  
10 processes is they need to be embedded in tikanga, designed, implemented, monitored and  
11 evaluated by tāngata whaikaha Māori and our whānau, to meet the diverse aspirations for  
12 well-being, and balance both individual and collective rights.

13 Secondly, I think that in any kind of process of restorative justice, one has to go  
14 back to the root causes of inequities and address those. There needs to be (inaudible), if  
15 you like, structural and process measures implemented that focus on providing an  
16 opportunity for equitable outcomes, including those in Care and Protection, Youth Justice  
17 residences, and prisons where whānau are currently being held.

18 Thirdly, I think it's really important that there is timely public monitoring and  
19 reporting of disaggregated data, high quality disaggregated data that includes ethnicity and  
20 disability data in ways that are responsive to the epistemological aspirations of mātauranga  
21 Māori of tāngata whaikaha Māori. That data needs to be disseminated by accessible modes  
22 and formats, it needs to be available to tāngata whaikaha Māori and their communities and  
23 it needs to include Māori data sovereignty principles -- actually, that data needs to be  
24 owned and governed by Māori with lived experience of disability.

25 Fourthly, and I think the most importantly, it is going to require a fundamental  
26 transfer of power to provide equity sustainable resources to tāngata whaikaha Māori. Like  
27 whaea Karen just said, we need to guarantee mana motuhake in the development and  
28 maintenance of both leadership, capacity and capability, mechanisms for effective  
29 monitoring and evaluation and redressing, and to ensure that Government actually delivers  
30 on obligations under Te Tiriti o Waitangi, as determined by tāngata whaikaha Māori  
31 themselves rather than Government determining the nature of those obligations, how they'll  
32 be honoured and in what way.

33 I think these are sort of high-level critical things, but when I reflect on current  
34 processes, I know this Commission is reflecting on historic processes, but I see the same

1 things repeating contemporaneously. You know, yes, we have this Commission of Inquiry,  
 2 and we have Wai 2575 going through the process. Their findings will not be timely, and  
 3 they will not be binding in a way that actually will inform the generational transformation  
 4 of the system that is currently proceeding without their recommendations.

5 There are currently -- I think one of the panelists spoke to coming to the table as  
 6 equal partners, coming to the table resourced. There are proposals, there are policy  
 7 developments, there are consultations going out today, this week, this month, that are  
 8 offering not only hours or days to engage and to have input into policies that are being  
 9 developed now.

10 Tāngata whaikaha Māori communities have not had any kind of systematic  
 11 investment that allow us to get into sort of a collective mind frame, into a position to  
 12 actually respond meaningfully, and I think investment in those mechanisms are a critical  
 13 underpinning of being actually able to engage in a genuine way.

14 **MS BAKER:** Kia ora, Tristram, thank you very much. I now would invite the Commissioners to  
 15 make a few closing reflections. I know that Commissioner Steenson, you wanted to ask  
 16 some questions potentially, but I'm sorry we are lacking in time. We will need to be able to  
 17 hand the rākau back to Ron to close with karakia and then I'd like to invite us to also  
 18 collectively sing Te Aroha just to close the session, or just to whakatau the Māori. So I'll  
 19 just hand over to you shortly.

20 **COMMISSIONER STEENSON:** Tēnā koe, I will still probably ask those questions, but thank  
 21 you. Tēnā koutou katoa. He taura waka e motu, he taura tangata e kore e motu. Nā reira he  
 22 taura tēnei nō Ngāti Whatua, he taura tēnei nō Tainui, he taura tēnei nō Ngāti Hine. He  
 23 taura anō hoki tēnei nō Ngāti Porou. He taura kua whiria kua tau ko Julia Stenson taku  
 24 ingoa. Tēnā koutou katoa. (I greet you all, the rope of a canoe can be severed but that of  
 25 people cannot. My rope is from Ngāti Whātua and Tainui and Ngāti Hine. I am also  
 26 connected to Ngāti Porou. And my rope has been plaited and here I am today, Julia  
 27 Steenson, I greet you all).

28 Just quickly, if I reduce it to one pātai (question), and I also want to extend an  
 29 invitation to just respond to Dr Ingham's wero about not having enough time, just invite the  
 30 panel to, if they have thoughts, we're absolutely open to receiving more submissions if any  
 31 of the panel members would like to do that in writing, or by a wānanga we can absolutely  
 32 organise that for you. So that was the first thing.

33 My pātai is, and I did have a few so I'm just deciding which one here. Before I do  
 34 that, actually, I want to also acknowledge and say tēnā koe, matua Ronald, for your kōrero

1 acknowledging my tūpuna o Ngāti Whātua today. (Thank you for acknowledging my  
2 ancestors from Ngāti Whātua, matua Ron).

3 My pātai is for Karen. You talk about currently there's only one Māori staff  
4 teaching. I think I've decided to choose this because it's somewhat representative across all  
5 manner of areas currently still in the disability areas.

6 I wanted to understand or know your thoughts on why that is, why is there only one  
7 Māori teaching staff?

8 **MS POINTON:** If I can just ask permission, I would like to hand over to my mate Carol, she is  
9 the staff member. So if that's okay to hand over to my mate Carol here, mana wahine, here  
10 we go.

11 **COMMISSIONER STEENSON:** We have her here.

12 **CAROL:** Kia ora, everyone, kia ora to the panel, kia ora to the Commissioners. There is a few  
13 Māori staff at Ko Taku Reo, say, maybe at the moment there's some -- most of the staff are  
14 Pākehā, and the majority of the students at school are Māori. Yeah, so it's not a balance.

15 **COMMISSIONER STEENSON:** I guess my question was understanding why that's the case.  
16 Do you have any insight? No?

17 **CAROL:** One thing that I would say is on the interview panel all the interviewers are Pākehā, so  
18 I've challenged that to say, "Where's the Māori Deaf on the interview panel?" And that has  
19 been put aside, so that would be my challenge. Yeah. So managing, controlling that  
20 situation, so yeah, that would be one thing would I say.

21 **COMMISSIONER STEENSON:** Tēnā koe, ngā mihi. Well, it's really just then for me to say  
22 thank you for the rich kōrero today that you've all provided. Yeah, there's a wealth of  
23 information there for us and some of it we are -- we've heard resoundingly throughout the  
24 last couple of weeks and you have certainly helped put that into a Te Ao Māori context for  
25 us. So, kei ngā kōuru nui te whakaruru nei i ngā tupu e puāwai ana. Tēnā koutou, otirā tēnā  
26 tātou katoa

27 **DR INGHAM:** Kia ora. I thank both the Commissioners and those in attendance today for  
28 listening. I would really like to take you up on that invitation to wānanga further on this  
29 kōrero. I think the pātai that you raised just then, whaea, was really telling. I think that that  
30 phenomenon extends all the way across all aspects of healthcare governance, and  
31 governance in a lot of areas where there may be a token Māori representation, but that  
32 representation is not often supported or substantive or in genuine partnership. And I think  
33 the broad experiences of many Māori that have held governance roles reflect systemic bias  
34 and discrimination against them being able to have their voices heard and do a good job in

1 representing the needs and aspirations of tāngata whaikaha Māori communities. So thank  
2 you for that question. Kia ora.

3 **MS BAKER:** Tēnā kōrua, Commissioner Gibson.

4 **COMMISSIONER GIBSON:** No pātai, just an acknowledgment of all the experience, the  
5 wisdom which has been brought by the panel today, stretching back generations, thank you,  
6 it's going to aid us in terms of our recommendations, and we look forward to any more  
7 engagement in the future, kia ora.

8 **MS BAKER:** Kia ora, thank you, tēnā koe. I'd like to thank all of the panelists and all of the  
9 people who have joined us on the livestream and in the room today for our public hearing.  
10 And we now move to close the session. Ron, we will be -- do we sing first or karakia first,  
11 kei a koe?

12 **MR BAKER:** We'll have a song first.

13 **MS BAKER:** Have a song? Okay, whānau, let us close or whakakapi our session with singing Te  
14 Aroha and then we will close with karakia.

15 **MR BAKER:** Kia ora tātou. It would be good if we had another opportunity, I know it's a rushed  
16 time mō tēnei tō tātou nei hui, so there might have another time, we might have some time  
17 together, it might be useful. So I started talking about wairua tapu and so maybe tō tātou  
18 nei waiata hei whakakapi nei i tō tātou nei hui. (Waiata Wairua Tapu). (Karakia).

19 **COMMISSIONER GIBSON:** Tēnā koe, thank you matua, we will now break for lunch and  
20 return at 1.45.

21 **Lunch adjournment from 12.54 pm to 1.56 pm**

22 **QUESTIONING BY MS THOMAS:** So Brigit, can you please introduce yourself to us all and  
23 tell us a bit about your qualifications.

24 A. Tēnā koutou katoa, ko Brigit Mirfin-Veitch ahau. My name is Brigit Mirfin-Veitch, I'm the  
25 director of the Donald Beasley Institute, the DBI, an independent research institute  
26 specialising in disability research.

27 I'm a sociologist and have been working as a disability researcher since 1994. I  
28 have a part-time role as a research associate professor with the University of Otago,  
29 Christchurch, and I provided expert evidence as part of the contextual hearings at the  
30 beginning of the Commission.

31 I think the other important thing to say is that I contribute to the Commission in  
32 other ways, mostly through reference group involvement.

33 **Q.** Thank you. And as we go through your evidence today, which is very important evidence,  
34 we do need to speak slowly and take our time for the interpreters --

- 1 A. Sure.
- 2 Q. -- to cover everything that you have to say. Can you tell us a little bit more about the  
3 Donald Beasley Institute and what it is?
- 4 A. Yes, the Donald Beasley Institute is an independent charitable trust. We have been on the  
5 disability landscape and the wider disability sector providing disability research for  
6 approximately, or nearly four decades. I have had the great privilege to work with the  
7 institute for three of those nearly four decades and over the past 30 years the DBI has  
8 witnessed both the closure of institutions and the evolution of the community-based support  
9 system.
- 10 Q. And has the DBI had quite an active role in research around the deinstitutionalisation  
11 process?
- 12 A. Yes, we have.
- 13 Q. Last week we heard from a witness Paul Milner who was involved working with the DBI  
14 during the Kimberley Project on deinstitutionalisation. Has the DBI done any other work  
15 in that area?
- 16 A. Yes, I think it's important to say that all of our work over the time that we've been in  
17 existence has prioritised lived experience and inclusive rights-based disability research.  
18 We seek to do research that challenges or has the potential to challenge and change the  
19 system, the systems, and to make a difference in disabled people's lives.
- 20 That work has included exploring processes used to move disabled people out of  
21 institutions, and documenting what life was like before and after they lived in those  
22 settings, and just like the work that Paul described last week around Kimberley.
- 23 Q. Has the DBI also been part of the call for the establishment of this Royal Commission that  
24 we're in today?
- 25 A. Yes, in 2017 we undertook a literature review-based project about the experiences of  
26 disabled children and adults in State care. Those research findings led us to title the report  
27 "Institutions are Places of Abuse" because of the prevalence of abuse that we found in  
28 publicly available documents that tell stories of institutional care.
- 29 Q. So, on the basis of the research that the DBI had undertaken, did you conclude that there  
30 was an absolute need for this Royal Commission of Inquiry?
- 31 A. Yes, it would be very fair to say that on the basis of all of the research that we have done  
32 over the past 30 years, we held the view that a Royal Commission of Inquiry into Abuse in  
33 Care was long overdue.

- 1 **Q.** The focus of your evidence today that we're going to come on to is a research project that  
2 the DBI has just recently completed, the Tell Me About You project. Can you tell us how  
3 this project has come about?
- 4 **A.** Yes. The Tell Me About You project was designed to make sure that people with learning  
5 disabilities and people who identify as neurodiverse had the same opportunity to share their  
6 experiences about State and faith-based care as other survivors. We really wanted to make  
7 sure that their voices were heard in this Commission.
- 8 **Q.** So, did you and your research colleagues work in alternative ways to engage with disabled  
9 survivors and people with learning disability and people who are neurodiverse?
- 10 **A.** Yes, we did. Fundamentally we drew on our long history of inclusive narrative-based  
11 research to craft a sort of unique approach that had the potential to engage with people with  
12 learning disabilities, people who are neurodiverse in a way that enabled them to tell their  
13 own stories in their own way and we partnered with other people to achieve that goal.
- 14 **Q.** I know you would like to make some acknowledgments before we get underway in the  
15 depth of the report. Would you like to make those now?
- 16 **A.** Yes. At this point it's important to acknowledge my co-researchers and colleagues on the  
17 project, so Kelly Tikao, Hilary Stace, Umi Asaka, Eden Tuisaula, Robbie Francis Watene,  
18 and Patsie Frawley, most of whom are here today. While I'm the spokesperson today, it  
19 was definitely a collective effort of disabled and nondisabled researchers.
- 20 **Q.** Would you also like to acknowledge and name the members of Te Kahui Arataki?
- 21 **A.** Yes, I would. I would like to name the members of Te Kahui Arataki, our Māori  
22 governance group whose wisdom and experience both guided and supported our mahi, so  
23 ngā mihi nui ki a koe Huhana Hickey, Gary Williams, Bernadette Jones, Kirsten Smiler,  
24 Tania Thomas, Kerri Cleaver, Matthew Whiting, and Tuari Potiki, all of you people  
25 constructively pushed and challenged us to get things right for tāngata whaikaha and we  
26 learned a lot.
- 27 **Q.** What were some of the important aspects of the research design?
- 28 **A.** One of the most important aspects of the research design and I think the thing that the  
29 Commission was interested in in us doing the work was our use of individually responsive  
30 methods, what we refer to as IRM.
- 31 **Q.** Can you tell us what is IRM, what does that mean?
- 32 **A.** IRM was developed by researchers from the DBI and our colleagues as a way of including  
33 the voices of all disabled people in research.

1           So, often, researchers are committed to values of inclusive research, but-- don't offer  
2 a range of methods that might make research more accessible to disabled people.

3 **Q.** So how is the IRM, or the individually responsive method, different from the more  
4 traditional approach of research?

5 **A.** Instead of offering one pre-determined way of taking part, IRM offers people lots of  
6 different ways to participate in research about a particular topic.

7 **Q.** And did the people that engaged in this research project take up that opportunity to engage  
8 in these different ways?

9 **A.** Yeah, they certainly did. In our project people could choose from a list of different  
10 methods to tell their story. So, they could choose Kaupapa Māori methods, they could  
11 choose to just sit and talk, they could choose walking methods, so being on site at the place,  
12 the former institution or care setting, they could bring or use personal archives, things that  
13 were important to them or told something about them in their lives. They could use art-  
14 based approaches. They could tell their story with the help of a trusted person. They could  
15 tell their story online or using assisted technology as we saw with Lusi yesterday.

16 **Q.** And was this IRM approach also aligned with the trauma informed approach?

17 **A.** Yes, it was. So IRM is aligned with trauma, the trauma informed values of safety,  
18 trustworthiness, choice, collaboration, empowerment, but most importantly requires us as  
19 story gatherers to build relationships of trust.

20 **Q.** Throughout the life stories in your report, you've used the term "storytellers" rather than the  
21 term "survivors". Can you talk to us about that?

22 **A.** Yes, first of all we want to make it very clear that we deeply respect the kaupapa of the  
23 term "survivor" and "support" that's used in relation to the Royal Commission, and you'll  
24 hear me use it later. However, we were also aware that some of the people who might want  
25 to take part and who would eventually choose to take part in the research would tell stories  
26 of abuse in care, --and they would not necessarily recognise the actions towards them as  
27 abusive, nor use the term "survivor" to describe themselves.

28 **Q.** So, your research team used the term "storyteller" and in terms of the research team going  
29 out to work with all these individuals, were they all called "the story gatherers" effectively?

30 **A.** Yes, yeah, so "storyteller" is a term that DBI has used in previous narrative inclusive  
31 research with people with learning disabilities and our research team were referred to as  
32 "story gatherers" to indicate that the story tellers had the power, and we were simply there  
33 to help them put the story together.

- 1 **Q.** And given the sensitivity of the topic and what was being discussed throughout this  
2 research, how did the team make sure that all of this research was safe?
- 3 **A.** First of all, I'd like to say that as a research institute that specialised in disability research  
4 and particularly learning disability research for a very long time, we're 100% committed to  
5 disabled people being able to freely participate in research and to be presumed to have the  
6 competence to do. But we're also very committed to ethics and so before the research got  
7 started, our project was assessed by no less than two ethics committees, one the Research  
8 and Ethics Advisory Panel within the Royal Commission, and by the Health and Disability  
9 Ethics Committee, New Zealand's national Ethics Committee.
- 10 **Q.** And what about informed consent?
- 11 **A.** We were also really committed to as many people as possible being able to take a part in  
12 the research, even if they were people who others might have thought didn't have the ability  
13 to give informed consent. So we made sure that we were as inclusive as possible by taking  
14 a supported decision-making approach to informed consent and working very carefully at  
15 each stage of the process to make sure people were very aware of what was going to  
16 happen if they took part in the research, particularly what would happen to their story.
- 17 **Q.** So the life stories in this research report, the Tell Me About You report, is it correct, or  
18 accurate to say the heart of this report are the life stories?
- 19 **A.** Yes.
- 20 **Q.** Can you tell us a little bit about, yeah, that heart of your report, the life stories?
- 21 **A.** So I'm conscious today that we're not going to do justice to those stories, we are probably  
22 going to focus on parts of people's stories, so I do want to stress that yes, those stories are  
23 the heart of our work, there are 16 stories, they are highly individual and personal stories,  
24 and they make up the bulk of this report. It will be available very soon.
- 25 We also wanted- Te- Kahui Arataki, our Māori governance group for the project  
26 and our research team view these stories as precious taonga or gifts. So this report and my  
27 evidence today is dedicated to all the storytellers who had the courage to share intimate  
28 details about their lives before, during and after being in care. Their resilience and their  
29 continuing resistance is remarkable. And it's also dedicated to disabled people across  
30 Aotearoa who have never had the opportunity to tell their own stories about their  
31 experiences in care.
- 32 I said that the last time I gave evidence and I think the statement is still correct, we  
33 haven't got to everyone yet.



1 **Q.** Thank you. I can just reiterate, having read all of those 16 life stories, they are essential  
2 reading and just such an important part of this work. We will today in your evidence be  
3 asking you to call on those stories as we take you through the rest of the report, primarily  
4 the findings and the discussion parts.

5 In terms of the findings taken from these life stories in the research, you and your  
6 research colleagues have applied the ecological model of disability violence and abuse as a  
7 framework to analyse the life stories. Can you tell us what do you mean by this ecological  
8 model of abuse?

9 **A.** A challenging question and there's probably a better expert in the room than me right now.  
10 But yes, we did apply an ecological model of disability abuse and violence. And to try and  
11 explain simply the ecological model of disability violence and abuse provides a framework  
12 for exploring and for understanding the factors that impact on disabled people, to create  
13 environments where violence and abuse is able to occur. And it encourages us to look at  
14 the way these different factors interrelate and influence each other.

15 **Q.** So this ecological model of abuse, is this an international model for disability violence and  
16 abuse?

17 **A.** Yes, it is.

18 **Q.** So is this an appropriate model for Aotearoa New Zealand to be using to address disability  
19 violence and abuse?

20 **A.** The ecological model has been used right around the world and so it's very highly valued  
21 internationally. We think it has potential here and it's certainly provided a really useful  
22 instructive lens for us to look collectively at the stories we collected as part of Tell Me  
23 About You. But it's a reasonable question to ask, Ruth, and our team and some others,  
24 other researchers have just been funded by the Health Research Council of New Zealand to  
25 conduct a project about how we can develop an approach to violence prevention that is  
26 founded or based on the Te Tiriti o Waitangi, but that is inclusive of the principles of the  
27 ecological model. So we will be able to answer that question more fully in a couple of  
28 years' time.

29 **Q.** So, it's a watch this space?

30 **A.** Mmm.

31 **Q.** Excellent. Over the past eight days at this public hearing survivors and former staff  
32 members have shared abuse that they've experienced in care, and some themes have just  
33 consistently and repeatedly come out, and I'll just list a few: For example a lack of love,  
34 separation from whānau, lack of understanding of what abuse is, environments and spaces

1 devoid of privacy, culture where staff may consider watching abuse as entertainment,  
2 people have complained but not been believed, complaints may have been investigated but  
3 not eventuated in any formal response, there's been a culture of fear among residents to  
4 make a complaint for their own safety, and a culture of fear among staff to say something  
5 for fear of their own jobs and personal safety.

6 So these themes and topics have come up repetitively. How does the ecological  
7 model of abuse help us all to consider those separate factors?

8 A. Because it provides a way to explore the examples that you've given according to four  
9 separate but interrelated levels or areas that all have the potential to create the context or  
10 environments where the abuse that you've described is able to occur.

11 Q. So what are the four levels?

12 A. The four levels are individual, relational, community, and societal.

13 Q. So how does analysing disability violence and abuse across those four different levels help  
14 us in our work?

15 A. I've sort of pondered this and the most straightforward way I can use to describe it is that  
16 the ecological model gives us a framework that can help us to understand why abuse  
17 occurs, what responses are needed to address it, and what strategies are likely to be most  
18 effective for preventing violence and abuse from occurring in the future.

19 Q. Is there a common misconception about, inverted commas, disabled people and a causative  
20 factor of abuse or violence?

21 A. Yes.

22 Q. Can you tell us what is that misconception?

23 A. This is also something that I knew I'd be asked and have spent some time thinking about.  
24 But the misconception as I see it is that disabled people are inherently vulnerable and  
25 therefore disability abuse and violence is inevitable. So both aspects of that misconception  
26 to me are distressing and morally wrong.

27 The reason for that is that the first part places blame for the abuse on disabled-- on  
28 the disabled person, and the second part suggests that there is societal acceptance of  
29 disability violence and abuse and a complacency.

30 Q. Did one of the witnesses just yesterday speak to this?

31 A. Yes, Leeann left us with a very strong challenge at end of the day yesterday, at the end of  
32 her evidence, and I agree, I think turning the tide on the persistently high level of abuse  
33 experienced by disabled people will take the commitment of all New Zealanders as Leeann

- 1 challenged us with, and that's because this abuse is grounded in the attitudes and  
2 assumptions that we all hold about disabled people.
- 3 **Q.** What does the ecological model do to challenge that "vulnerable victim" label and  
4 misconception?
- 5 **A.** That model offers us a way to challenge these assumptions that link disability identity and  
6 lived experience to being somehow inherently or automatically vulnerable to violence and  
7 abuse.
- 8 **Q.** How does it challenge this?
- 9 **A.** It requires us, at the risk of sounding too much like a researcher, but it requires a really  
10 close and critical examination of how those assumptions interact or have interacted at the  
11 individual relational, community and societal level to create the environments where abuse  
12 is able to occur.
- 13 **Q.** Right. And so we're now going to go through some of those levels in a way that we can  
14 hopefully all gain some understanding from.
- 15 **A.** Hopefully.
- 16 **Q.** We'll start with the individual level of this model. How does the individual level challenge,  
17 what we've just discussed, this misconception that places blame for violence and abuse with  
18 the victim of that abuse?
- 19 **A.** So I think it requires a little bit of background before I answer that question properly.
- 20 **Q.** Sure.
- 21 **A.** But some approaches to understanding and responding to violence and abuse, either  
22 intentionally or unintentionally, place blame for violence and abuse with the victim. So in  
23 other words, personal characteristics or individual characteristics of disabled people  
24 become the reasons why other people think the abuse has happened.
- 25 **Q.** Right, yes.
- 26 **A.** So in other words, reasons for abuse get put forward, like "disabled people don't know the  
27 difference between right and wrong", or "they are hypersexual" or "they don't feel emotion  
28 in the same way as non-disabled people", or "they can't give consent because they haven't  
29 got capacity." These are all things that are used to explain away abuse in many ways. And  
30 so that leads us to ways of responding to abuse that also put the responsibility for fixing the  
31 problem on the person.
- 32 **Q.** Right. So again, the assumption that a disabled person is more vulnerable to abuse because  
33 of their disability is completely wrong?
- 34 **A.** In my opinion, yes.

- 1 **Q.** When the Donald Beasley Institute analysed the life stories in the Tell Me About You  
2 project, what did the researchers find in relation to this individual vulnerability?
- 3 **A.** We found that the storytellers were not inherently vulnerable and did not inherently lack  
4 capacity, but while they were in care, they almost universally experienced a lack of agency,  
5 a lack of rights, will and preference, and a lack of recognition of their personhood.
- 6 **Q.** Right.
- 7 **A.** And in our view, they experienced a lack of all of those things because other people  
8 assumed that they lacked competence because of their disability label or identity.
- 9 **Q.** And then the report then goes on to consider each of those sub-themes under this individual  
10 level?
- 11 **A.** Yes, it does.
- 12 **Q.** So if we could just go through those themes now and start with the first one that you've  
13 mentioned which is lack of agency, and I'd like you just to simplify and tell us what is lack  
14 of agency, what does that mean?
- 15 **A.** In plain language "agency" simply means having choice and control over your own life, and  
16 those of us that are immersed in the disability world will hear those words frequently.  
17 Shannon, who gave evidence yesterday, did a really excellent job of explaining agency  
18 when he talked about his desire to determine the direction of his own life, and to make his  
19 own decisions about how to get where he wanted to get to.
- 20 **Q.** Right. When in institutions or care settings, what did the storytellers tell your colleagues  
21 about the agency that they did over their lives?
- 22 **A.** In bald terms people didn't have any control over their lives. The care settings they lived in  
23 determined the course of each day and people had very little choice and control over any  
24 aspect of their daily lives, while they were in those settings.
- 25 **Q.** Can you give us an example from one of the story tellers in your research, Graham P, after  
26 he got out of Cherry Farm?
- 27 **A.** Yes, Graham's example or what he talked about when he was talking about his person  
28 about his life now was when -- he said, "I like my room here, it's comfortable, I have my  
29 own things in my room, I have a TV set, I have more control and I can be myself, look after  
30 myself, I do my dusting, it makes me happy, I can relax in my room."
- 31 **Q.** Right.
- 32 **A.** So these are seemingly very small pleasures and decisions that he's taking, but you can see  
33 how highly valued they are when he'd had the experience of them being taken away.

- 1 **Q.** Right. I'm sorry but I'm going to have to ask you to move maybe even the base of the  
2 microphone even closer.
- 3 **A.** Sure.
- 4 **Q.** There we go. It's quite intrusive but it's right there, the microphone, thank you.  
5 What did the storytellers say about their independence when they had come out of  
6 the institutions?
- 7 **A.** This was interesting as well. When people emerged from the care system for some  
8 storytellers at least they felt as though they had changed, so now they were able to do things  
9 for themselves. For example, one person said, "Living out of Templeton now has changed  
10 me. I go down to the supermarket, have coffee with friends, they make me coffee in my  
11 cup, and I go and sit by the table and drink it. I tell staff where I'm going. I can just say I'll  
12 be back any time."
- 13 **Q.** So when you hear this evidence, what does it show you or how do you interpret those  
14 responses?
- 15 **A.** We interpreted it that people didn't recognise that they were always --well, they always had  
16 the right, but that they were always capable of doing those things and it was the system that  
17 had prevented them from doing that.
- 18 **Q.** Is that possibly similar to the evidence we've heard last week from Allison Campbell when  
19 she spoke of Sir Robert Martin saying to her, "I'm becoming a person"?
- 20 **A.** Mmm.
- 21 **Q.** I think she said, "You've always been a person"?
- 22 **A.** Mmm.
- 23 **Q.** The second sub-theme at this level, this individual level of factors is a lack of recognition  
24 of rights, will and preference?
- 25 **A.** Mmm-hmm.
- 26 **Q.** Can you tell us before we get into that, what is meant by the term "will and preference"?
- 27 **A.** Yeah, I have to give a small lecture here. So, the terminology is really drawn from Article  
28 12 of the United Nations Convention on the Rights of Persons With Disabilities, so I think  
29 everyone will understand about rights. But in Article 12 it talks about supported decision  
30 making and decisions being based on a person's will and preference. So, a person's ability  
31 to make decisions that are of their own choosing and that are not imposed on them by what  
32 other people think is best for them.
- 33 **Q.** Right. Why did the storytellers that you've engaged with have a lack of will and preference  
34 in their lives?

- 1 A. The answer to that is the same answer as to why people didn't have agency.
- 2 **Q.** Right.
- 3 A. So, from our perspective storytellers' experiences indicated they weren't seen as rights  
4 holders and related to that, they were assumed to lack the capacity to express their will and  
5 preference or to make their own decisions based on what they wanted, in other words.
- 6 **Q.** Can you give us an example from one of the life stories in the report about a storyteller who  
7 was not given her right to express her will and preference in care?
- 8 A. Yes, and, you know, Lusi who gave evidence so powerfully yesterday springs to mind here.  
9 Lusi is someone who requires access to communication devices and technology to be able  
10 to communicate without restriction. For her, she was critically compromised in this regard  
11 due to a lack of tools and strategies to support her communication when she lived at  
12 Kimberley and without those strategies and tools and devices, she was unable to express  
13 her will and preference easily and clearly to people.
- 14 **Q.** So obviously yesterday Lusi used an electronic device, but historically other  
15 communication tools have been available, but they weren't made available in Kimberley?
- 16 A. Shannon, giving his evidence yesterday, also demonstrated that to us too, how important  
17 communication is.
- 18 **Q.** So, by not being provided the tools and support needed to communicate her will and  
19 preference, how did this impact Lusi's life, what did she say in her life story about that?
- 20 A. Well, Lusi, again, told us very, very clearly yesterday, and it's been reported around the  
21 nation today, that she felt invisible to the world when she didn't have access to  
22 communication, and the devices she needed. That ability to freely express herself was not  
23 possible while she was in care and therefore, she couldn't show herself to the world.
- 24 **Q.** What was another example in the research gathered of will and preference being ignored?
- 25 A. As someone who's done a lot of family research in my past, one of the things that really  
26 stood out clearly to me was, in terms of will and preference being denied or ignored, was  
27 the universal experience of being disconnected from family or whānau. So, it didn't matter  
28 what was going on for people at home, they all wanted to stay there, and what we heard,  
29 and have heard right across the eight days of this hearing, is that that desire to be with  
30 family and whānau or stay with family and whānau was often ignored, disrespected or, in  
31 some cases, actively kind of broken.
- 32 **Q.** Is there an example in the life stories from Michael on this point?
- 33 A. Yes, the example from Michael really shows his ambivalence; the absolute desire to see his  
34 family but the absolute pain when they left again. And so, he put his feelings into words in

1 the following way: "Mum and dad came up and visited me but it was hard leaving, saying  
2 goodbye to them," and his will and preference would have simply been for him to stay with  
3 his family, but the system decided for him and his parents that he would be better off in  
4 care. And that was due to his disability.

5 **Q.** We've also heard in the course of the last eight days, and it's relevant in the life stories in  
6 this research project, about loss of identity. Do you have an example from the research  
7 project that you'd like to share with us?

8 **A.** Yes. I think loss of identity was central to all the stories, and really starkly illustrated in the  
9 case of Sarah and her brothers.

10 **Q.** Could you give us a brief overview. -I know her story is very detailed and thorough in  
11 the -report -but to summarise, to an extent, her story for us now?-

12 **A.** So, Sarah's story is traumatic and, in our view, could serve as a case study of systemic  
13 abuse. Her story painstakingly tracks her journey to find her brothers, one of whom she  
14 didn't know existed until she was an adult. So, integrating her efforts to find her brothers  
15 with inaccessible, incomplete and dehumanising records held by the system about them was  
16 the way that her story was crafted. And she discovers that the reason, or she discovered  
17 that the reason that she couldn't find one of her brothers was because he'd been living in  
18 that system for many, many years with another man's identity, and this had occurred due to  
19 a series of failures in documentation and a system that didn't seem to care enough to find  
20 out who he actually was.

21 **Q.** In relation to this loss of identity, what does Sarah say about this in her life story?

22 **A.** This is directly from Sarah's story, and it says: "Sarah noticed that Paul's date of birth had  
23 changed about three times over the decades. The admission application had the wrong date  
24 of birth, his date of birth had changed in the institution on some documents, and decades  
25 later the agency had yet another date of birth for him. It would turn out that the agency had  
26 the birth certificate of a completely different person to Paul. The Christian and surnames  
27 were correct, but the date and place of birth and the parents' names were all incorrect for  
28 Paul. He had another man's identity. After Sarah managed to prove their sibling  
29 relationship, a new birth certificate was ordered and the old one ripped up."

30 **Q.** To move on to the other theme that was mentioned, the lack of recognition of personhood.  
31 What does "personhood" mean?

32 **A.** Like all of these concepts and ideas we're discussing, there could be a number of different  
33 definitions used. But in the context of this research, we took "personhood" to refer to the

- 1 respect for an individual's essence of being, freedom to make choices and have autonomy,  
2 or independence, freedom to love and be loved, and to belong and to relate with others.
- 3 **Q.** Why does the Donald Beasley Institute report say that there was a lack of recognition of  
4 personhood within the accounts of the research that you've gathered?
- 5 **A.** Because when we look across the 16 stories, all bar one really show repeated assaults on  
6 personhood or a lack of recognition of personhood. But one of as-- just one example,  
7 personhood was challenged by medical practitioners and other staff in care settings as one  
8 of the things we noticed in relation to personhood.
- 9 **Q.** How did the medical practitioners or staff challenge a person's personhood?
- 10 **A.** What we saw was storytellers being infantilised and devalued through the use and labels of  
11 language, labels like "feble-minded" were common. Again, if people read Sarah's story,  
12 you will see what we mean by these labels and language.
- 13 **Q.** When personhood was removed, what was the consequence of that?
- 14 **A.** It was used when-- that sort of dehumanising language or people weren't seen as human  
15 occurred, it was seen as --or used as a justification for the removal of people's human  
16 rights, and their agency. So that's why it's really important to pay attention to things like  
17 language.
- 18 **Q.** Is it fair to say --when someone's not valued, or someone's been dehumanised then it's  
19 easier to see it's-- easier to justify the abuse that then is carried out against that person?
- 20 **A.** Yeah. And in my opinion, it continually circles back to a presumption of incompetence  
21 underwriting those things.
- 22 **Q.** When personhood was challenged by the medical staff or professionals and staff in the  
23 research that you gathered from the storytellers,-- what did the researchers observe about  
24 what disabled people did with those labels when they were labelled by these people?
- 25 **A.** Yeah, many, many times storytellers identified themselves by the labels that other people  
26 had attributed to them. So that is, their identity and their perceptions of themselves became  
27 echoes of those labels and attitudes that they were subjected to.
- 28 **Q.** Does the storyteller, a person called A, make a point on this?
- 29 **A.** Yes. A is someone who was subjected to a lot of labelling and it impacted how he saw  
30 himself, and he tried to explain to me what it felt like to be him, and he said, "When I was  
31 at high school I wouldn't speak to anyone or anything or any person, any peoples, I was,  
32 what do you call it, I was sort of -- I wouldn't even speak to peoples or anything, eh, I don't  
33 really know why, but I was a bit worried people would tease me."
- 34 **Q.** Right.



- 1 A. And for this person, in comparison to a lot of the other abuse and violence that he  
2 experienced, we might think this is quite a small thing, but to him it was something he  
3 spent a lot of time thinking about and talking about in his story.
- 4 Q. Another challenge to personhood that comes through in the life stories is inhumane  
5 treatment. Can you give us an example from the storyteller Graham P?
- 6 A. Yeah, so going from the example that I just gave of how people saw themselves or  
7 perceived themselves, the other end of the spectrum of assaults on personhood was  
8 violence, and Graham said about his experience of overt abuse, such as being locked up,  
9 was: "Sometimes I would get angry and yell out and put holes in the walls. I find it a bit  
10 hard to talk about being at Cherry Farm, I don't like thinking about it, I don't like Cherry  
11 Farm."
- 12 Q. Thank you. I'm now going to move us on to the relational level within the model. We've  
13 heard a lot of evidence particularly yesterday and even in the day's prior about power and  
14 control in relationships, as a factor that enables abuse. Is there an important additional  
15 factor at this relationship level of the model of disability violence and abuse?
- 16 A. So the relationships or relational level of the model invites and enables a critical  
17 consideration of power and control in the relationships disabled people have with family  
18 and whānau, with peers, with intimate partners, with co-workers-, with people in the  
19 community, but importantly to this Royal Commission, it also asks questions about  
20 relationships disabled people have or are part of because of their -- the label of "disability",  
21 so that includes relationships with paid carers, with educators, with health and allied health  
22 professionals, and workers in the disability service system, past and present.
- 23 Q. So how did the required relationships that disabled people have in their lives affect the rates  
24 of abuse of disabled people in Aotearoa when compared to non-disabled people?
- 25 A. We can unequivocally state now that research confirms that whānau hauā or tāngata  
26 whaikaha Māori and disabled people in Aotearoa experience violence and abuse at higher  
27 rates than non-disabled people.
- 28 Q. What are the key features of the relational level of disability violence and abuse?
- 29 A. The key features of the relational level are that others have power over and are the  
30 decision-makers about the way relationships are conducted and managed. Other features  
31 are that there are limited opportunities for disabled people to form, to manage and to  
32 mediate equal and respectful relationships across their lives. And research has found that  
33 this is particularly the case in relationships that people are part of because of their lived  
34 experience of disability.

- 1 **Q.** The research report also refers to the phrase "corruption of care". Can you please tell us  
2 what is this corruption of care?
- 3 **A.** The "corruption of care" is a term used by a UK researcher Paul Cambridge. Paul  
4 Cambridge spent time in Aotearoa a number of years ago, speaking about these issues.  
5 And he found in research that within disability service environments disabled people are at  
6 risk of abuse due to the way these relationships frame disabled people as being of lesser  
7 value, and dependent and without agency or the ability to make their own decisions.
- 8 **Q.** Are you able to give us an example to illustrate this corruption of care point based on one  
9 of the life stories or some of them?
- 10 **A.** All of the stories, bar one, illustrated that while in care storytellers were seen as being of  
11 lesser value, as being dependent and without agency, and that these were relational features  
12 of the environments that they were in. But if I can only, give only one example, Graham  
13 P's is a good one, something that I've come back to a lot in his story. He said, when he was  
14 thinking about the relationships he had with staff in an institutional setting, he said: "I liked  
15 them, I treated the staff like family, they didn't treat me like family. Made me sad a bit, no  
16 one would comfort me when I was sad."
- 17 **Q.** So is it fair to say that exposure to being in a care service or requiring one of these people  
18 in your lives increases a person's risk to being abused?
- 19 **A.** Yes, for all the reasons that we've just talked about, but not because of the person  
20 themselves.
- 21 **Q.** No. The subthemes at this relational level that have been highlighted in your research are  
22 that others holding power over, others making decisions about their lives, lack of  
23 opportunity to form respectful relationships. If we go through some of those subthemes  
24 now and, firstly, the "others holding power over" topic, what was an example of this that  
25 was noted in the research report?
- 26 **A.** Most of it. So, storytellers experienced direct and repeated physical abuse, emotional and  
27 psychological abuse and neglect, particularly in the form of forced seclusion, or in the form  
28 of sexual abuse at the hands of people they came into contact with because of their  
29 disability and their perceived need for care by professionals or the system. So these  
30 experience evidence that people who were supposed to care for them had power that they  
31 misused or abused.
- 32 **Q.** I'm going to move on to a question about the term "playing up". So what were the  
33 storytellers told by staff about why they were put in seclusion or why they had been  
34 assaulted?

- 1 A. The storytellers that described being restrained and locked up often used to talk about,  
2 when we would ask why that happened or when that happened, they would say, "It  
3 happened when I played up." So the consistency with which some of the storytellers, with  
4 learning disability particularly, linked incidents of abuse and violence against them by  
5 institution staff suggests that they were told that that violence that they were subjected to  
6 was justified because of their behaviour, that they were the cause of the violence.
- 7 **Q.** Right. Today, what do people more readily understand about someone's behaviour when  
8 they might be playing up?
- 9 A. As Dr Olive Webb explained during her evidence last week, contemporary understandings  
10 of communication and behaviour would tell us that playing up is a very common way for  
11 some disabled people to communicate and to express their lack of power when other people  
12 fail to listen to them.
- 13 **Q.** When the storytellers in the research project describe their effort to communicate their  
14 distress or frustration or lack of power in a way that looked like playing up, what typically  
15 happened to them?
- 16 A. Their efforts to communicate in those settings tended to result in punishment and that was  
17 most often meted out in the form of violent, physical restraint and forced isolation.
- 18 **Q.** Is there a quote from one of the storytellers Allan that you'd like to read on this point?
- 19 A. Yes. Allan's example isn't as extreme in terms of the response, but it is very illustrative.  
20 He said: "Because when staff didn't understand me and expect me to do things that I wasn't  
21 sure about, then they'd yell at me for getting it wrong and then I would explode. They  
22 would just see me as a person who was trying to be naughty or out to be dangerous. And  
23 that wasn't the case at all. I think there was a misunderstanding, and I wasn't being listened  
24 to, is what the problem was."
- 25 **Q.** Is there also an example that can be seen in Sarah's story about her brother?
- 26 A. Mmm-hmm. This is a more horrific example, which is in Sarah's story and it says: "There  
27 are illnesses that sometimes take weeks to diagnose and reports of problematic behaviour,  
28 deemed to be Paul's growing aggression, including his waking early and screaming, which  
29 required his being put in a quiet room and medicated and that turned out to be physical pain  
30 requiring surgery for gangrenous appendicitis, and other times dental problems which were  
31 eventually identified."
- 32 **Q.** The next sub-theme in this level is about others making decisions about their lives and  
33 dictating the rules of relationships. Can you give us an example of this?

- 1 A. This was particularly obvious in the management of family and whānau interactions and  
2 relationships, storytellers always shared how they missed their family while they were in  
3 care. However, decisions about when family members were able to visit or when they were  
4 able to return to their family were controlled by their care providers.
- 5 **Q.** Is there an example that you'd like to read from Sarah's story on this?
- 6 A. Mmm, Sarah said, the following Christmas, with different staff members on, they chose to  
7 eat separately to the residents and assumed that the sister would not want to do the same.  
8 Sarah was dismayed, she had worked hard, saved up money and travelled a long way to  
9 break bread with her brother again on Christmas Day. She said it felt like her brother was  
10 being separated out from her again and she realised that he and his peers would probably  
11 never be seen as true equals by others. She watched on as her brother and his peers were  
12 fed separately like cattle, apart from the people in charge.
- 13 **Q.** That part of Sarah's story is she travelled from another country to come back to spend  
14 Christmas with her brother and yet --
- 15 A. So even when Sarah was in the setting, the separation and the segregation and the  
16 controlling of the relationship still occurred.
- 17 **Q.** The next sub-theme at this relational level is the lack of opportunity to form and manage or  
18 mediate equal and respectful social familial peer and intimate relationships?
- 19 A. Mmm-hmm.
- 20 **Q.** You've said that the storytellers in the research shared an overall experience of having little  
21 opportunity to form respectful relationships. How do you describe the impact of this at a  
22 relational level?
- 23 A. Quite simply the deprivation of significant relationships for storytellers can be described as  
24 a covert form of violence and abuse.
- 25 **Q.** Is there a useful example of this from Lusi's story?
- 26 A. Yes, and I think Lusi spoke about this yesterday, with the example of, she said, "while I  
27 was in Kimberley Centre my mum never visited me. The first time she came was when she  
28 came to take me home. I didn't know who she was, and I felt nervous."
- 29 **Q.** Moving on to the community level of the ecological model now, can you tell us what is  
30 this, what does "the community level" mean?
- 31 A. The community level represents the places and structures that already exist or are formed  
32 by society when people come together and contribute and participate.

- 1 **Q.** Are there differences in-- these places or structures where communities come together and  
2 contribute, are there differences for disabled people when compared to non-disabled  
3 people?
- 4 **A.** Yeah, so for many people the community is a place of belonging and civic contribution.  
5 However, for many disabled people, the-- community is experienced as places of exclusion.  
6 As we heard yesterday in the evidence of Lusi and Matt and Shannon and the many other  
7 disabled survivors over the past eight days.
- 8 **Q.** What does the community level of the model require us to do about this difference?
- 9 **A.** Like the other levels, it challenges us to think about how disabled people are framed in  
10 communities, including how the framing impacts on and shapes how they're positioned and  
11 responded to alongside other members of the community.
- 12 **Q.** What do you mean by "how disabled people are framed", can you just expand on that?
- 13 **A.** How they're seen by the community, including how other people's perceptions of how  
14 disabled people belong or don't belong, or contribute or don't contribute, so how they are  
15 seen.
- 16 **Q.** What does this level and the analysis, what does it illustrate?
- 17 **A.** It illustrates how the way communities' position disabled people impacts on the  
18 experiences that are available to them, and the extent to which they experience the benefits  
19 or risks associated with being inside or outside of a community.
- 20 **Q.** Your report details some of the sub-themes under this community level as, for example, a  
21 lack of access to housing, employment, education, people being understood as non- or  
22 unproductive community members, understood as recipient of services and supports and,  
23 effectively, in servitude, and understood as non-citizens. Could you take us through some  
24 of those themes, starting with the lack of access to housing, employment, and education?
- 25 **A.** Yeah. The stories in Tell Me About You illustrated a fundamental erosion of the right to  
26 make decisions about where to live and where to make a home. None of our storytellers  
27 had that right.
- 28 **Q.** How did this happen, how was the right to decide where to live eroded?
- 29 **A.** Some storytellers described that they entered care due to a lack of support for their family  
30 or whānau. Others shared that they didn't know why or how they'd ended up in State care.
- 31 **Q.** Is Graham, does he comment on this?
- 32 **A.** Mmm, both aspects are present in this comment which was: "Then I was at Cherry Farm.  
33 I remember when I went but I don't remember how old I was or why I went there.  
34 I remember feeling angry when I got there because I didn't want to leave home."

- 1 **Q.** Was there also an account from one of the storytellers around education as a reason for why  
2 siblings entered care?
- 3 **A.** Yes. This storyteller, family storyteller shared that her siblings entered care in part because  
4 they were perceived as being unable to participate in education. The perception was they  
5 couldn't be educated because they were mentally retarded. She said in the 1960s it was  
6 widely considered that mentally retarded or autistic children did not have the capacity to be  
7 educated.
- 8 **Q.** That was in the life story from Sarah?
- 9 **A.** Mmm-hmm.
- 10 **Q.** The theme of being understood as non- or unproductive community members, how was this  
11 reflected in the life stories of the research?
- 12 **A.** Running through most of the stories was an understanding or social construction of  
13 storytellers as non-productive or unproductive, and this was clearly reflected in their work  
14 experiences or lack of work experiences, and particularly in the prevalence of unpaid or  
15 underpaid work.
- 16 **Q.** Did David make a comment about that in his story?
- 17 **A.** Yes, he said: "I worked at the printers in Templeton, not paid though. I didn't really like  
18 my job in the printers, the ink stunk, and it made my hands dirty." But what he's really  
19 saying is that he had no choice over what work he did.
- 20 **Q.** Being understood as recipient of services and supports and in servitude to the state was  
21 another theme. By being in care, how were the storytellers perceived at the community  
22 level in this regard?
- 23 **A.** Many of the storytellers were fundamentally and permanently assigned to the role of  
24 recipient of services and supports. And that started with that initial act of being placed in  
25 care. So being the recipient of services and support sometimes meant they were placed in  
26 different institutions or care settings one after the other, and as the quote just a little earlier  
27 here indicated, not knowing why those changes in setting were being occurring-- for them.
- 28 **Q.** I'm just going to move on to the next theme of being understood as non-citizens, which was  
29 one of the themes at this community level. How were these storytellers in the research  
30 deprived of citizenship?
- 31 **A.** They were deprived of citizenship by being placed in institutions and prevented from  
32 leaving; they were deprived of citizenship in being restricted in who visited and when they  
33 visited; through being expected to undertake unpaid or low paid work; they were deprived  
34 of citizenship by --having limited access to life experiences, to education, to training that

1 might support their ambitions for the future; and due to their containment, they were  
2 excluded from being authentic members of their communities, including being able to  
3 develop that sense of belonging that we heard is so important across these eight days, and  
4 that is typically associated with being part of a community.

5 **Q.** When you and your colleagues were gathering these stories did the storytellers reflect on  
6 their lives after the institutional care, and when they did this, did this give you an insight  
7 into some of the community level factors that were actually present during their time in the  
8 institution?

9 **A.** So I think some of the most instructive comments about the erosion of community and  
10 belonging are seen when storytellers reflect on their life beyond the institution or care  
11 setting, and even Rosie who was quite-- had a particular experience of a care setting that  
12 was more positive than others, said: "We had a choice, when we were in the institution, of  
13 who we lived with, but when I got out I found it was great to be in the community and  
14 I didn't look back."

15 **Q.** Thank you. We'll move on to the final level of this ecological model of abuse, which is the  
16 societal level.

17 **A.** Mmm-hmm.

18 **Q.** How can we begin to understand the impact of the societal level as a factor contributing to  
19 disability violence and abuse?

20 **A.** Like the other levels, understanding how social structures impact on and shape disability,  
21 violence and abuse, also requires recognition that the way society works and is structured is  
22 framed by privilege and power, which is embedded in our economic and political and social  
23 policies and practices, that focus on the dominant and most productive members of society,  
24 and the storytellers that we talked about certainly didn't fall into that category.

25 **Q.** How does society give some people the power and privilege and not others?

26 **A.** Through discriminatory or ableist laws and policies and through systems that give some  
27 people access to power and privilege, including access to education, and employment, and  
28 networks that enable access to valued social roles and opportunities. And again, these  
29 storytellers we spoke with and the survivors that have been speaking across this hearing  
30 have all talked about not having access to those things.

31 **Q.** And can you tell us how this exclusion and discrimination has been able to occur?

32 **A.** For disabled people there's a history of exclusion from those systems and discrimination  
33 within them.

34 **Q.** And the impact of ableism?

- 1 A. Mmm-hmm, is embedded in society and operates in the way social structures are designed  
2 and accessed and used.
- 3 Q. Why is the societal level of the ecological model so significant in terms of prevention of  
4 future abuse?
- 5 A. So, while it's the furthest from the individual, it has arguably the most significant impact in  
6 terms of being able to shape the structures and ideas and attitudes that have a direct impact  
7 on individuals and that we need to change.
- 8 Q. So in terms of future prevention of abuse and neglect of disabled people in care, while all of  
9 the four levels that we've gone through need to be addressed, is it fair to say that the  
10 societal level factors may have the most significant impact. --
- 11 A. Yes.
- 12 Q. -To influence transformative change?-
- 13 A. [Nods].
- 14 Q. Your report goes through the societal level with some sub-themes. The first one that's  
15 covered is "Laws and policies that deny personhood rights". The New Zealand laws and  
16 policies that led to the era of institutional care, what value system were they built on?
- 17 A. I think it's fairly clear by now that the policies relating to support for disabled people in the  
18 era we're talking about were developed in response to a system which valued segregation or  
19 was based on segregation.
- 20 Q. How did one of the storytellers describe this in the report?
- 21 A. I seem to be drawing on Lusi's wisdom quite a lot today. But she explains it perfectly by  
22 saying: "It is built on a system that dehumanises disabled people."
- 23 Q. What power did these policies have?
- 24 A. They had tremendous power. We are talking about a time when those policies provided the  
25 mandate for disabled people to be isolated in environments that were cold and dark and  
26 blatantly, so I'm talking literally and figuratively there, that blatantly denied personhood  
27 and positioned people away from communities and the wider society.
- 28 Q. Looking at the theme of societal factors around education, employment, and health models  
29 that segregate and specialise, what model of support was offered to disabled people and  
30 their families by society's structures and policies?
- 31 A. The support offered, again, followed the model of segregation really. So people in this  
32 research and much of the other research that we've done around this topic consistently  
33 showed that families only had one option, they weren't being supported to care for their  
34 disabled family member very well at home and in the community.



- 1 **Q.** Your report also lists as a theme here "The limited access to legal and social protections".  
2 In terms of this theme, what did your research show about access to complaint mechanisms  
3 or justice?
- 4 **A.** It can reasonably be asserted that disabled people in care that we spoke to had little  
5 effective control over the way they were treated, they had no clear pathway to justice for  
6 seeking accountability for violence and abuse that they either experienced or they  
7 witnessed, and the stories attest to that.
- 8 **Q.** And is there an example in the research, I think it might be drawing again on Sarah's  
9 account?
- 10 **A.** Yes, who shared about the over-medication issue for her brothers and at the time there was  
11 no pathway to question or challenge the treatment regime being administered. And this did  
12 not occur until they moved into the community. She said: "The decades of charted  
13 medication records indicate a heavy regime of drugs for epilepsy, anti-psychotics,  
14 behaviour control and sometimes pain relief. Only after deinstitutionalisation and the  
15 involvement of psychiatrists were questions raised about psychiatric polypharmacy despite  
16 there not being any record of any diagnosis of mental illness."
- 17 **Q.** And the last sub-theme under this level was framed as "Outsiders in society". What does  
18 that mean at this level of the model?
- 19 **A.** For all storytellers' supporting treatment was provided outside or away from mainstream  
20 society. We've heard that repeatedly. Societal attitudes of the time meant that when  
21 support or treatment was sought, the person was placed out of sight in institutions that were  
22 geographically and relationally on the margins of their communities.
- 23 **Q.** Your report then weaves these four levels together, and by doing that, how does that assist  
24 when considering strategies for prevention of abuse and violence in the future?
- 25 **A.** I'll defer to an international expert on this, Andrea Hollomotz, who says:  
26 "If we do that it enables us to understand how social and individual factors interact  
27 in the formation of risk of violence. This allows us to focus our gaze beyond the  
28 assumption of vulnerability and with this to move away from dominant explanations of  
29 individual cause."  
30 So that issue we were speaking about earlier.
- 31 **Q.** Right. Just looking now at if-- we could move to the discussion aspect of the report where  
32 yourself and your colleagues analysed the collective body of all of the life stories. When  
33 you did that, what did your analysis confirm?

1 A. When we used this model, where we got to was that we identified and confirmed that  
2 systemic abuse within care had a pervasive impact on the experiences of storytellers at all  
3 levels of the model.

4 **Q.** What is systemic abuse?

5 A. Again, we don't have time to go into lots of detail, but in brief, it refers not only to direct  
6 physical abuse that a person experiences, but the violence inherent within and to a system.

7 **Q.** And acknowledging that you could probably talk on this for a few hours, but what did you  
8 and your colleagues conclude in terms of the abuse and violence described in the life  
9 stories, was it systemic?

10 A. Yes.

11 **Q.** And why did you conclude that?

12 A. It's probably, what I'm going to try to do is to give a composite story. So at, so- I'm  
13 drawing on all of- the stories to provide an answer. So at the beginning of each storyteller's  
14 care journey, the system granted power and authority to professionals to make decisions  
15 about where that person would live and who and how they should be cared for.  
16 Storytellers, and often their families, were almost totally voiceless in those decisions about  
17 care.

18 When storytellers moved into institutions and other care settings, day-to-day carers  
19 continued to hold power over them, creating the potential for violence and abuse, the  
20 corruption of care we talked about earlier. And if we think about systemic abuse, it  
21 includes conditions and policies that are abusive. It -includes and-- these include  
22 inappropriate punishments and neglect, and these were prevalent in the experiences of  
23 storytellers.

24 And the other thing that happened is that even if some institution staff and other  
25 people in caretaking roles didn't agree with what was happening, they were as powerless as  
26 the storytellers to challenge it. So all of this suggests ableism and disablism at play.

27 **Q.** During your research report, you analyse the, also the experiences of survivors that have  
28 given evidence at the Royal Commission hearings, previous hearings, and I think you found  
29 that the evidence gathered in the life stories of the Tell Me About You report mirrored the  
30 experiences that the Commission has been receiving. What conclusions did the Donald  
31 Beasley Institute make about this in the research report?

32 A. It was fairly stark. We said from survivor testimony it is clear the systems put in place by  
33 the State to support and protect children and young people catastrophically failed many of  
34 them repeatedly and we said that that constituted systemic abuse.

1 **Q.** Does your report then go on to list how the State categorically failed to support and protect  
2 children and young people?

3 **A.** Yes, it does.

4 **Q.** Would you like to just summarise those points that you made in the report?

5 **A.** We said that children entered care needing support and protection either for their disability  
6 or due to circumstances at home, or both; that the lack of State support for children to  
7 remain in the families dismantled and fractured families; that children and young people  
8 who deviated or -- and I'll add adults there as well -- or who were perceived to deviate from  
9 the norm were not supported, and placed in State care; the impacts of abuse affected those  
10 children, young people and adults for the rest of their lives and often into the next  
11 generation; that staff members were often aware of abuse and remained complicit and  
12 complacent by not reporting it; and children and young people disclosed their abuse but  
13 were often accused of lying; and --

14 **Q.** Sorry, it carries on?

15 **A.** And one more was the care system left survivors of abuse and neglect feeling unloved,  
16 unworthy, as deserving of being abused and suggesting that they had in turn internalised the  
17 ableism and disablism themselves.

18 **Q.** And for all of those reasons, your conclusions were that the State had categorically failed  
19 these children, young people and disabled adults catastrophically?

20 **A.** In my brief, yeah.

21 **Q.** If we move now to your conclusions in the report. There is a comment made on the phrases  
22 that some people look back and say these things have happened historically, they were the  
23 practice of the day. What would you like to say in response to that phrase with reference to  
24 the examples in the life stories that you've gathered?

25 **A.** I think one of the challenges that we are facing in this Royal Commission is a repeated  
26 refrain that some people believe that or that is based on the belief that history shouldn't be  
27 judged by today's standards. However, what the Tell Me About You storytellers told us  
28 about their experiences might have been common but it doesn't mean it was right and it  
29 shouldn't be explained away as the practice of the time.

30 So what I would say to that is that taking young people away from whānau and  
31 fracturing cultural identity is not acceptable practice and never was; ignoring the rape of a  
32 child within foster care is not acceptable practice and never has been; administering  
33 medication using violence or as a punishment is not acceptable practice and never has been;  
34 locking people up and isolating them from others without lawful reason is not acceptable

1 practice and never has been; punching people you were paid to care for is not acceptable  
2 practice and never has been; hanging disabled children from a clothesline is not acceptable  
3 practice and never has been; not knowing why you live somewhere and not being able to  
4 leave that place is not acceptable practice and never has been; and having clinicians  
5 encourage your peers to verbally abuse you in the context of therapy is not acceptable  
6 practice and never has been.

7 So these are just some of the stark examples of abuse and violence in the lives of  
8 disabled children and adults recounted by the 16 storytellers in Tell Me About You and  
9 they are all a denial of personhood.

10 **Q.** Just finally as we conclude your evidence today, I'd like to shift to look forward. In  
11 New Zealand currently we are on the crest of transformation in the disability support sector  
12 with the Whaikaha, Ministry of Disabled People and the roll-out of Enabling Good Lives.  
13 In drawing on your expertise in this area, do you have any comments or concerns around  
14 these changes alone being sufficient to address the violence and abuse of disabled people?

15 **A.** It's good to be able to focus on the positives for a moment. So Whaikaha, the ground-  
16 breaking Ministry of Disabled People, the first Ministry designed and led by disabled  
17 people and framed by Te Tiriti o Waitangi and the Convention is one major systemic  
18 change that has the potential to improve and address this horrific record of systemic abuse  
19 of the scale that has been described over the past eight days.

20 Related to that, commitment to the national rollout of Enabling Good Lives which is  
21 informed and influenced by whānau ora and underpinned by values like self-determination  
22 and person-centred, mainstream first, mana enhancing, etc. I know I've missed a few.  
23 That's a really important systemic transformation as well, that also has the potential to  
24 reduce systemic abuse.

25 But those measures alone won't fix the problem and those structures alone shouldn't  
26 have to fix the problem.

27 **Q.** So in your expert opinion, what do you see in addition to these things we've just described  
28 as essential for real change?

29 **A.** I'll go back to a point I made earlier and, in my opinion, what still needs to happen is for  
30 Aotearoa New Zealand to make a real commitment to the legislative and policy change  
31 required to fully implement Article 12 of the United Nations Convention on the Rights of  
32 Persons with Disabilities.

33 **MR WHITING:** Hear hear.

1 A. UNCRPD experts have long said that the realisation of all other rights asserted within the  
2 Convention hinge on Article 12.

3 So to continue with my lecture, if we think about the focus of the Royal  
4 Commission and analyse the evidence that disabled survivors have contributed, it's clear  
5 that if disabled people were recognised as having legal and mental capacity as per Article  
6 12, and were supported to make decisions according to their own rights, will and  
7 preference, the violence and abuse in care that we have heard about over the course of the  
8 Royal Commission and this hearing would not have been able to continue unchecked.

9 So, yeah, in my view we should be using the powerful tool that we signed up to, the  
10 UNCRPD. Almost without exception every right expressed in the UNCRPD gives us a  
11 way to counter disability violence and abuse and its impacts. But at the very least, we need  
12 to fully implement and regularly and comprehensively monitor Articles 14 to 17 of the  
13 Convention, which are arguably the most directly relevant to this Royal Commission and to  
14 the recommendations that will emerge from it. And obviously that needs to occur under the  
15 overarching framework of Te Tiriti o Waitangi and the United Nations Declaration for the  
16 Rights of Indigenous People.

17 **Q.** Can I ask you where to from here in terms of the evidence that has been gathered, the life  
18 stories, the survivor accounts? What do you say about this evidence that has been  
19 gathered?

20 A. I've got a few opinions on that as well. The stories we have collected and all the others that  
21 have been contributed to the Royal Commission must be elevated from their previous status  
22 of invisible disability history. They need to be preserved and engaged with over time, and  
23 this Commission is just the tip of the iceberg, as has been referred to in evidence earlier in  
24 this hearing.

25 We need to think really carefully about how the evidence is provided, that has been  
26 provided to the Commission as preserved for future use. There are some examples we can  
27 look to, and we need to think about how we continue to provide pathways for people to  
28 report and record stories of their abuse in care over time. Not everyone will be ready to  
29 talk in the timeframe of this Commission, we know that.

30 **Q.** And the Royal Commission of Inquiry's relevant period of investigation under its terms of  
31 reference is 1950 through to 1999. What would you like to say about that timeframe?

32 A. I think we need to be very clear that abuse did not stop in 1999. It has not gone away, and  
33 we need to continue to be vigilant, we need to be activists, we need to keep listening. And  
34 we need to critically ask ourselves if a contemporary examination of disability abuse is

1 required. Whatever is decided, the end of this Royal Commission or the stated date of the  
2 end of this Royal Commission is not the end or should not be the end.

3 **Q.** During the evidence and question time yesterday, there was a discussion about the need for  
4 disabled people to continue to be activists and to champion any recommendations that are  
5 made from this Commission. What would you like to say on this point?

6 **A.** We need to celebrate the resilience and the resistance of survivors and their whānau and  
7 allies, but one of the things that we, one- of the messages that we're carrying forward from  
8 Te- Kahui Arataki is that we should not be using people's individual and collective strength  
9 as a reason to diminish or allow ourselves to put aside the horrendous impact of systemic  
10 abuse. We need to acknowledge and promote ongoing activism and the mana of disabled  
11 people and their representative organisations to highlight and respond to abuse, but in my  
12 opinion those individuals and those organisations need to be properly resourced with the  
13 formal mandate to implement and embed the recommendations that will undoubtedly come  
14 out of this Commission.

15 **Q.** It was also part of the discussions yesterday that this Commission does end at some point in  
16 the middle of next year. In your opinion, when does this important work in this area end?

17 **A.** Ultimately, the work of the Royal Commission will not be done until all New Zealanders  
18 understand that it is societies and systems that make people vulnerable to abuse; disabled  
19 people themselves are not inherently vulnerable to abuse.

20 So again, in my opinion, to continually recycle the notion that disabled people are  
21 somehow responsible for abuse, for the abuse they experienced, is dangerous and it will  
22 never lead us to the place where we can confidently assert "never again."

23 **Q.** Finally, Dr Mirfin-Veitch, would you like to finish your evidence today with your final two  
24 paragraphs from the Tell Me About You report?

25 **A.** Sure, I think it's appropriate to take us back to the 16 individual storytellers who made this  
26 work possible. We ended our report by saying: "This report has captured the stories of only  
27 a small number of disabled people," and I think that's an important take home message.

28 "There are many more disabled people in Aotearoa New Zealand who will never get  
29 the opportunity to share theirs. The DBI research team acknowledges the bravery it took  
30 for every single storyteller to share their story and recognise that for some storytellers  
31 participating in Tell Me About You forced them to relive the mamae they felt while in care.  
32 We are deeply grateful for their contributions, but we think that justice for storytellers and  
33 the many others who undoubtedly shared similar experiences will only be achieved if

1 redress is underpinned by Te Tiriti o Waitangi and implemented swiftly and universally in a  
2 way that is inclusive of and accessible to everyone."

3 **Q.** Thank you.

4 **A.** Thank you.

5 **Q.** I'll just see whether the Commissioners may have any questions.

6 **COMMISSIONER GIBSON:** Thank you, Brigit, thank you, Ruth. Commissioner Steenson, do  
7 you have any questions?

8 **COMMISSIONER STEENSON:** I do. Kia ora, Brigit.

9 **A.** Kia ora.

10 **Q.** Thank you for your statement. I just had one question around the definition that you've  
11 given on systemic abuse, which also says that it's interchangeable with institutional abuse.  
12 It just seems somewhat limited to an individual structure when it's defined that way as  
13 opposed to a --

14 **A.** Yes.

15 **Q.** -- a wider system issue?

16 **A.** I think the interchangeability of the two terms happened a long way back and so we would  
17 recommend dropping the "institutional abuse" term and just use "systemic abuse". But  
18 when you track its history back, it's used in the same way, it means the same thing. So  
19 just- yeah-.

20 **Q.** Okay, that's quite interesting, because my understanding was institutional abuse referred to  
21 a particular institution and the abuse that occurred within that institution.

22 **A.** Yeah, and it can be used in that way too.

23 **Q.** As opposed to the wider attitudes, legislative policies (inaudible) of systemic abuse?

24 **A.** Yes.

25 **Q.** Okay. That was --

26 **A.** So my recommendation is simply go with "systemic".

27 **Q.** It should be wider. Kia ora.

28 **A.** But we were just acknowledging some of the origins of that term.

29 **Q.** Thank you. That's all my pātai.

30 **A.** Great.

31 **COMMISSIONER GIBSON:** A lot of the kōrero reading the stories is about care in what might  
32 be called support services, some of it's in education. Do you think that the lessons that you  
33 talk about across the four levels of the ecological model, and also you talked about  
34 segregation, are equally applicable to both or is there some nuance?

1 A. I would have to say I would need to give it some more thought and apply it, but my initial  
2 response would be yes, it is applicable.

3 Q. And from your sense of what you learnt, the-- bulk of these stories comes pre-  
4 2000, - about- what's happening now, I think there has been a clear message that it's still  
5 ongoing but what would you say are the subtleties in what's changed, what's got better and  
6 what's got worse in the last 20 or so years?

7 A. So what we saw was I'll-- reframe that. Our analysis identified some key themes that were  
8 very extreme within the care settings and within the time period of the Royal Commission,  
9 but we still see people not having the opportunity to fully enjoy all their rights. In today's  
10 current settings we see care provided in a way that doesn't enable people to always express  
11 their will and preference about what happens for them. We see assaults on people's  
12 personhood, possibly in less overt ways, but not always, in the current setting.

13 So people were definitely happier about their moves away from the care settings we  
14 explored, but we certainly indicated, as three people who gave evidence yesterday said, that  
15 they still find it difficult to always have their rights met.

16 Q. A casual conversation last night with a survivor talked about, and this was in reference to  
17 survivors who had given evidence, but I think it perhaps applies to the same 16, how would  
18 we know that we've achieved anything, would it be useful come back in two years or a  
19 certain amount of time and collect some similar stories. Is there a methodology to know  
20 that we're actually making a difference and through that methodology to learn again and --

21 A. I think the methodology well--, the framework of the ecological model that we applied  
22 could be used in that way. We've identified the factors in each of the levels that contributed  
23 to the abuse that people experienced. You could apply, you could apply the same analysis  
24 and see if those things are present or apparent in people's lives.

25 Q. You talked, almost lyrically, about the resistance and resilience of disabled people and  
26 about the complacency and complicity of those involved in care. I think that was more at  
27 the relational level. When does complacency become complicity at a community level, at a  
28 societal level?

29 A. That's a really big question and I don't know that I've got the answer to it. But I, -do- you  
30 want to answer, Matt? [Smiles at Matt]

31 But I think I go back to some central themes in the evidence that I've given today  
32 and one of those central themes was trying to challenge the notion that the community and  
33 wider society has, that disabled people are inherently vulnerable, that would be a place to  
34 start.



1 **Q.** I think I can hear Matt's answer before I ask this question- so- would you say that society is  
2 complicit in the abuse and neglect of disabled people?

3 **A.** Yes.

4 **Q.** Thank you. I have no further questions, it's up to me to thank you. I've learned a lot from  
5 you over the years, it's been great to have read that the many reports- I- think I read 200 of  
6 the 250 pages last night and, again, the stories, the heart of the research jumps out at you  
7 that what has happened, the necessary change, the documenting of the history of what's  
8 happened in Aotearoa New Zealand. I think we've made another step, another significant  
9 step towards change. I'm hoping we get to that point where we can say "never again". And  
10 thank you and all the team at the Donald Beasley Institute, who I know are here and  
11 contributed to this research and the research on these issues over the years, we really  
12 appreciate it. It's not just academic, it is social change, it's challenging and it will make a  
13 difference. Kia ora and thank you.

14 **A.** Kia ora, Paul.

15 **MS THOMAS:** If we could take the afternoon adjournment until 4 o'clock, so 15 minutes?

16 **COMMISSIONER GIBSON:** Yes, 15 minutes, kia ora, thank you.

17 **Adjournment from 3.44 pm to 4.06 pm**

18 **COMMISSIONER GIBSON:** Ms Thomas.

19 **CLOSING STATEMENT BY THE ROYAL COMISSION**

20 **MS THOMAS:** Thank you, Commissioner Gibson. Over the last eight days of Ūhia te  
21 Māramatanga, this public hearing, we have heard from 23 survivors and whānau members.  
22 As we close this hearing this afternoon, we would like to acknowledge the very many  
23 disabled survivors, Deaf survivors, and survivors who have experienced mental distress,  
24 who have also provided evidence to this Royal Commission through their private sessions  
25 and through witness statements.

26 We would also like to welcome and encourage any more survivors who may like to  
27 come forward and engage with us.

28 We would also like to acknowledge the disabled survivors, Deaf survivors, and  
29 survivors who have experienced mental distress who have previously given evidence  
30 during the last three years of the Royal Commission's public hearings. We have compiled  
31 some survivor quotes from survivor evidence at these previous hearings and we've put them  
32 into a video which we will play now as part of the close of this public hearing.



1           Arthur Sainsbury was ahead of his time and his book documented similar human  
2 rights abuses as we have heard in this hearing. He should feel exonerated as these large  
3 institutions he warned about were indeed hell holes of abuse.

4           Additionally, his ideas for reform are today encapsulated in United Nations Human  
5 Rights Council reports and World Health Organisation guidelines on mental health.

6           New Zealand was never a back water when it came to psychiatric experimentation.  
7 From the 1940s onward patients were treated with various forms of electro-shock,  
8 lobotomies, and drugs. In fact, some of the treatments closely resembled the mind control  
9 experiments conducted by psychiatrists for the CIA in the 1950s through to the 70s.

10           This included intensive ECT or electric leucotomy practised in Nelson's Ngawhatu  
11 Hospital in the 1950s. Women there had their memories completely obliterated with  
12 electroshocks and had to be nursed like babies for months afterwards. Such "treatment"  
13 was written as successful in the New Zealand Medical Journal in 1958. We found  
14 survivors of this experiment and they had no memory of their former life and did not even  
15 remember their own families.

16           In his opening address the Crown counsel said New Zealand had a system that  
17 failed to understand, but this minimises the reality, serving only to mitigate the  
18 responsibility and accountability of the people involved in the abuse and those who ensured  
19 it remained hidden.

20           In actuality, we had a mental health system that segregated disabled people into  
21 large institutions, which enabled the psychiatric experimentation and abuse. Patients  
22 committed into State and mental health care had all legal and human rights stripped from  
23 them. They were powerless to challenge the abusive practices and were denied the right to  
24 refuse treatments that were harming them.

25           The Crown counsel also said that this abuse was "invisible", but this downplays the  
26 fact that for some it was entirely visible. Staff working in these facilities saw the abuse,  
27 even if they negated the cruel and inhuman aspects of it. It was not invisible to those ill-  
28 treating the patients or who should have been ensuring it did not occur.

29           It may not have been visible to the general public, but as we have heard in the past  
30 week and a half, a number of family members objected to the treatments but were ignored  
31 and the treatment continued. To them, the abuse was very visible, but they felt powerless  
32 to stop it.

33           For CCHR's statement to the Royal Commission I documented the more salient  
34 cases we worked on to give context in which to show a history of psychiatric abuse and

1 what the medical authorities did and did not do in response to our submissions demanding  
2 inquiries and change.

3 From the mid-1970s onwards CCHR documented and exposed psychiatric  
4 violations of human rights in Tokanui, Kingseat, Lake Alice, Porirua, Oakley, Sunnyside,  
5 and other hospitals, revealing many of the abuses heard by this Commission today. We  
6 exposed deep sleep and modified narcosis in nine psychiatric institutions and several  
7 victims were compensated, despite the Health Department and Medical Council's lack of  
8 findings against those psychiatrists who practised this form of experimental and damaging  
9 treatment.

10 We pressed for inquiries into the deaths of Mansel Watene at Carrington Hospital in  
11 1989 and Dolly Jane Pohe in the Rotorua psychiatric unit in 1991. We held our own  
12 Commission of Inquiry into a number of suicides at the Hastings psychiatric unit in the  
13 mid-1990s, resulting in an investigation by the Medical Council.

14 One thing for certain about these and numerous other cases, was they were never  
15 invisible. In fact, in some cases the media coverage was extensive and even front-page  
16 news. We campaigned for human rights in mental health care while medical authorities  
17 ignored the concerns of the patients and their families that had turned to CCHR for help and  
18 protection.

19 Authorities hid the real problems with sham investigations and inquiries that  
20 ignored real accountability by those involved. And there was the deafening silence from  
21 the Royal College of Psychiatrists.

22 And so, it has been in the 1970s, the 80s, the 90s and the 2000s. In any given year  
23 one could read news articles about the failed mental health system. Our records are full of  
24 these, including sexual abuse of patients, cruel and degrading treatment, preventable and  
25 even treatment driven suicides and death. These matters have hardly been invisible.

26 At the beginning of this hearing, we heard how the pseudo-science of eugenics led  
27 to the incarceration of disabled children in large psychopaedic hospitals. They were  
28 labelled as "feeble minded" and "abnormal" and then subjected to psychiatric drugs.  
29 Today, some psychiatric colleges in other countries have even apologised for the atrocities  
30 their profession committed against patients in the name of eugenics, which was passed off  
31 at the time as acceptable treatment.

32 A eugenics-like categorising of children still occurs today, but in a much more  
33 sophisticated way and on a far greater scale. Across the country, four-year-old children are  
34 psychologically screened as part of a "B4 school checks" health programme using

1 subjective checklists of behaviour symptoms. They are then categorised as normal,  
2 borderline and abnormal, which has led to thousands of interventions, including far greater  
3 numbers of younger children being put on antidepressants and antipsychotic drugs, not to  
4 mention psychostimulants such as Ritalin.

5 It would be of no surprise that this abuse could become the subject of a future  
6 Commission of Inquiry where the children, then adults, want to know why they were  
7 medicated with powerful mind-altering drugs when there was nothing wrong with them,  
8 except perhaps rambunctious childhood behaviour or normal reactions to bad conditions in  
9 their lives.

10 Our mental health system is based around compulsory and therefore coercive  
11 treatment, including psychiatric drugs and electroshock. On average, over 5,000 people are  
12 subjected to compulsory psychiatric treatment each year. Māori and Pacific people are  
13 over-represented in this.

14 Psychiatry asserts benefits from their treatments when there are none. Their  
15 reported statistics of "improved" from lobotomies and electro leucotomies given in the  
16 1940s and 50s were as high as 80%. To them, "improved" meant a docile, malleable  
17 person. Similar claims are still made today, and people subjected to their treatments see  
18 themselves as guinea pigs where the drugs are trialled on them. As the UN High  
19 Commissioner's report stated in February this year, the overreliance on mental health drugs  
20 is a "significant obstacle to the realisation of the right to health".

21 This was reflected in survivor Donna Phillip's testimony who said that to change the  
22 system, stop making drugs the central focus of treatment. She, like many others, said the  
23 drugs created a chemical dependency and takes away the person's ability to manage their  
24 own life.

25 One of the ways psychiatrists dismiss their failures is by blaming the poor outcomes  
26 of their treatments on the mental condition of the patient, labelling them as  
27 "non-compliant", "non-responsive", or "treatment resistant". This justifies more treatment,  
28 which means more drugs and electroshocks. They want legislation that allows this practice  
29 to continue.

30 The objections to this are not only CCHR's despite its knowledge gained from a  
31 long and tenacious history of fighting for patients' rights.

32 Last year, Dr Danius Puras, professor of psychiatry and former United Nations  
33 Special Rapporteur on the Right to Health said: "Let us assume that each case of using non-

1 consensual measures is a sign of systemic failure and that our common goal is to liberate  
2 global mental health care from coercive practices."

3 The UN has directed each member nation to abolish compulsory treatment from  
4 their mental health laws because such treatment can amount to torture. The Special  
5 Rapporteur against Torture said that it is essential to "promote accountability for torture and  
6 ill-treatment in healthcare settings by identifying laws, policies and practices that lead to  
7 abuse; and enable national preventative mechanisms to systemically monitor, receive  
8 complaints and initiate prosecutions.

9 The UN Committee on the Rights of Persons with Disabilities reinforced this in a  
10 2014 paper, saying that:

11 "States parties must abolish policies and legislative provisions that allow or  
12 perpetrate forced treatment, as it is an ongoing violation found in mental health laws across  
13 the globe, despite empirical evidence indicating its lack of effectiveness and the views of  
14 people using mental health systems who have experienced deep pain and trauma as a result  
15 of forced treatment."

16 Part of the redress survivors are asking for is a change in the mental health system.  
17 They want to see that perpetrators of psychiatric abuse are held to account.

18 The UN Human Rights Commissioner recommends that a holistic, not biomedical,  
19 approach to treatment be implemented and that there is recourse for those harmed or  
20 damaged by treatment or practices in the mental health system. We must move away from  
21 the long-entrenched idea that harmful, coercive practices are part of standard mental health  
22 care.

23 A good many of the abusive treatments documented at these hearings, as well as  
24 many CCHR has investigated in the past, could fall under crimes of torture, where  
25 punishment, ill and degrading treatment in psychiatric care occurred. Compensation now  
26 rests with the Government through a redress scheme that truly acknowledges the harm done  
27 to them.

28 With this Royal Commission, Aotearoa New Zealand can truly set itself on the path  
29 to eliminating coercive practices so that legislation can never again enforce abuse in the  
30 name of mental health treatment. In its place can be instilled a system of human rights and  
31 accountable care.

32 CCHR should never again need to resort to making formal complaints to the United  
33 Nations Committee Against Torture to ensure justice is done in our mental health system.

34 Thank you very much.

1 **COMMISSIONER GIBSON:** Thank you, Mr Ferriss, and can I acknowledge you and the  
2 Citizens Commission on Human Rights, the work you've done over the years. We  
3 acknowledged that in the Lake Alice hearing, your advocacy in uncovering what happened  
4 there back in the 70s and your continuing support for the survivors there through to the UN.

5 I've read your extensive evidence and it's impressive and thank you for your, you  
6 and your organisation's tenacity and endurance and your advocacy over so many years for  
7 people with mental health conditions and survivors, and those who did not survive mental  
8 health institutions. Thank you.

9 **MR FERRISS:** Thank you.

10 **COMMISSIONER GIBSON:** Now, closing statement for the Crown, Mr Allan.

11 **CLOSING STATEMENT BY THE CROWN**

12 **MR ALLAN:** Tēnā koutou katoa, e te mana whenua o tēnei rohe, Ngāti Whātua ki Ōrākei, tēnā  
13 koutou. E ngā Kaikōmihana, tēnā koutou, e ngā mōrehu katoa, tēnā koutou katoa. (I  
14 acknowledge the home people, Ngāti Whātua Ōrākei of Ōrākei, greetings. The  
15 commissioners, greetings to you. To all of the survivors, I greet you).

16 Thank you, Commissioners, for the opportunity to present a brief closing statement.

17 In relation to the address that we have just heard, the Crown said many things in its  
18 opening, and one of those was that the Crown's responsibility is not to deny or diminish, it  
19 is to accept and to acknowledge that abuse occurred.

20 But this closing address is directed primarily to the survivors who have come here  
21 over the past several days, whose traumas have been revisited. To each of you, thank you.  
22 Thank you for sharing your truths, for some you not for the first time.

23 Many other survivors have not been able to attend this hearing. You have spoken  
24 for them too. In speaking out, you have each outlined and coloured in a shameful picture of  
25 inhumanity. We appreciate too that this is not the full picture; that your statements to this  
26 Royal Commission cannot truly capture years of abuse and of life lost.

27 You have told us of deprivation, of being denied personhood and of being denied  
28 voice. We heard of the loss of childhood, of education, and of capacity to trust. We heard  
29 of over-medication and seclusion, and of people who arrived speaking or even singing but  
30 left silent.

31 We heard remarkable stories of resilience, but we heard too of the tragic  
32 consequences of despair and demise. Together, all of your stories carry a collective weight.  
33 One person described this collective weight as a national disgrace.

1           In looking ahead, the Crown is mindful of the need to walk backwards into the  
2 future. Hei whakakapi i tēnei kōrero, ka tiki ake ahau i te whakataukī e whai ake nei, kia  
3 whakatōmuri te haere, whakamua. (To conclude, I reach for this proverb; let's go  
4 backwards in order to move forward).

5           The wisdom in this whakataukī is immensely important. The Crown expects to  
6 discuss the shape of change in a later hearing of this Royal Commission, but what the  
7 Crown has heard in this hearing is invaluable. We have heard that we need to speak with  
8 disabled people and ask what they want in their lives. More than that, we have heard of the  
9 need for disabled people to take a lead in this work. This is being reflected through  
10 Whaikaha, the Ministry of, not for, Disabled People. It needs to be reflected across other  
11 parts of the system too.

12           We have heard that it takes humanity to be a good ally. We heard that we need to  
13 think about how to approximate familial care, and we heard of the vitality of respecting and  
14 enabling cultural ties.

15           We heard about the dangers of institutionalisation making abuse almost inevitable,  
16 yet we also heard a concern about replicating these dangers in community settings, the risk  
17 of developing a system in which customers are funders with bottom lines, not real people  
18 with human needs and aspirations.

19           We have heard also of the importance of funding and of the continuity of funding.  
20 We have also heard of the vital importance of putting people at the centre; he tangata, he  
21 tangata, he tangata (it is people, it is people, it is people).

22           But we heard also that any authentic conversation about this requires more and  
23 better training. This address, these brief words from the Crown now, cannot do justice to  
24 the stories and lessons that we have heard.

25           I can only say for the Crown that your sharing of these experiences has been vital  
26 and will remain vital to the task of effecting lasting change. As I said at the outset of this  
27 hearing, the Crown has been listening to what you have said as part of a broader continuing  
28 process to effect lasting change. As you told us again and again, what happened to you  
29 must never happen again.

30           So once more, thank you for your determination and for revisiting your experiences.

31           The Crown also acknowledges the whānau of survivors. You have shared your own  
32 stories of suffering, and these too are stories of struggle. Unfairly, they are also stories of  
33 guilt. Thank you for sharing those.



1           The Crown is also grateful for the caregivers and others who have given evidence of  
2 life within the State system. You have helped us to understand the stories we have heard,  
3 not as disparate experiences, but as a collection of experiences, unified in character, impact  
4 and, importantly, cause. Your insights supply the threads that help us stitch together the  
5 bigger picture, unsightly as it is.

6           Ko tōku mihi whakamutunga ki a koutou ngā mōrehu mō to koutou maia, me te  
7 kaha, ki te whakapuaki i o koutou kōrero. No reira, tēnā koutou, tēnā koutou, tēnā tātou  
8 katoa. (To conclude, my greeting goes to you the survivors for your bravery and your  
9 strength to share and express your story. Therefore I greet you all). Thank you.

10 **COMMISSIONER GIBSON:** Kia ora, thank you, Mr Allan, thank you to the Crown, and thank  
11 you for acknowledgement to survivors, he purapura ora, and to your commitment to effect  
12 lasting change. Kia ora, thank you.

13           Some closing comments now from Commissioners. Commissioner Steenson.

14 **COMMISSIONER STEENSON:** E mihi ana ki a tātou. Me mātua mihi nā purapura ora me  
15 tangata whaikaha e tupu ana he mana nō rātou. Tēnei te mihi, tēnei te mihi, tēnei te mihi,  
16 ngā purapura ora. (I acknowledge us all and especially those that are thriving, the power  
17 that has grown forth from them, that they have shown).

18           I just wanted to first acknowledge the survivors and their mana in sharing the kōrero  
19 that they have shared, it's definitely a taonga for New Zealand, not just this Commission.  
20 And not just to those survivors who have bravely shared their accounts over the course of  
21 this hearing, but also the survivors who have been following the hearing and also those who  
22 are not with us and not able to have their voices heard. So I just wanted to first  
23 acknowledge that.

24           I'm going to leave it to Commissioner Gibson really to do a full mihi and  
25 reflections, but I did want to say a couple of things. Firstly, that what we have heard over  
26 the last few days is hopefully going to be, as one of our survivors coined it, the  
27 foundational change that is needed, it will help us drive those foundational changes that can  
28 be long lasting, and hopefully intergenerational.

29           I think some of the things have been, as they have with all of the Commission's  
30 hearings, pretty shocking for us to hear as a nation in the way that our most vulnerable have  
31 been treated and so it's important that we take that as a wero (challenge) and even past this  
32 Commission's work.

1           The second part is, I'll-- leave the thanking of everybody to our Chair, but I did want  
2 to thank our Chair, Commissioner Gibson, for his efforts this week and also for our  
3 Commissioner Coral Shaw who couldn't be here due to illness.

4           Nā reira tēnā koutou, otirā tēnā tātou katoa. (With that I greet you and  
5 I acknowledge us all).

6 **COMMISSIONER GIBSON:** Tēnā koe, Commissioner Steenson, thank you for your thanks.

7           A few reflections. We're uncovering the history, we're opening a light, Ūhia te  
8 Māramatanga, on what happened to many of us disabled people, our history, our  
9 whakapapa which hasn't been told before in the past, so thank you for listening, thank you  
10 for those who shared.

11           We've heard similar stories to what we've heard in many of the other hearings which  
12 are less focused on disability, on disabled people, on people with mental health conditions,  
13 on Deaf people, but they were there as well, there were some of those stories and some  
14 come through, and perhaps some additional themes coming through again today. There  
15 was abuse of all kinds, physical, sexual, emotional, psychological, there was pervasive  
16 neglect in a way perhaps that we haven't heard in other hearings.

17           Dehumanising systems of power and control, those little day-to-day things which  
18 rendered people's lives meaningless which built to something more. These little things  
19 which are not the headlines we see about abuse, but these are what destroyed the lives of  
20 many people.

21           Some of the horrific things we've heard, regimes and institutions like concentration  
22 camps, we heard stories of sex being sold out of Government run institutions by staff  
23 employed by Government, it was like paedophile rings, extreme overmedicalisation,  
24 medical neglect and unfortunate drug experiments, solitary confinement, tools of torture  
25 being made up, devices made to give shocks to people, ableism, racism, colonisation,  
26 breaches of Te Tiriti o Waitangi sat behind all of this.

27           Voices of those who were denied their culture, denied their whakapapa, denied  
28 whānau, voices that otherwise would have never been heard. Stories of those whose so-  
29 called care either caused or contributed to their death, the discovery of unmarked graves,  
30 the forgotten lives of many who lie across Aotearoa, sexual abuse, physical abuse, neglect,  
31 denial of language, voice, voice, communication, silencing, invisibleness. The denial of the  
32 rights to make your own decisions, your own simple decisions and your own complex  
33 decisions, denial of identity, and family and whānau. No love, no hugs to children, to

1 adults. Catastrophic failures that led to this on relationship levels, on provider levels, at  
2 community levels and at societal level.

3 We've also heard that the things that happened pre-2000, so much of this is still  
4 going on, the power and control systems are happening now, the same systems are in place,  
5 the systems which were performed successfully if they were designed to create the power  
6 and control structures which led to abuse and neglect for people out of sight, out of mind  
7 are still performing successfully and that denial of rights and the ongoing abuse and  
8 neglect.

9 There's a gap in understanding between what the disability community has seen and  
10 experienced and what the wider community is thinking, and I think that gap needs to close.

11 While we've heard about the resilience and resistance of disabled people and, at  
12 times, their family members, their supporters, there is still a complacency, and at times a  
13 complicity from those who have been responsible for care and the wider society. We need  
14 to understand that and challenge that and make a difference.

15 We've heard from secret keepers, from survivors, from storytellers, we've  
16 heard -- we've witnessed courage and determination, we've heard calls that this is not just a  
17 talk fest, but that each of us examines what we can do in our own roles, perhaps even check  
18 further down the track, are we making a difference, have we heard what we've heard and  
19 are taking this forward to some reasonable change, the good lives that we all aspire to,  
20 disabled people, people with mental health conditions can and should aspire to and have as  
21 well.

22 It requires a commitment of all New Zealanders, it requires the commitment of you,  
23 of each and every one of us.

24 We also heard the strong cry of "nothing about us without us", disabled people  
25 leading and that the solutions are those who have the wisdom of experience and who have  
26 built a broader collective wisdom of experience.

27 And finally, we need to challenge ourselves to -- now that there is light, now that  
28 we've begun the process of Ūhia te Māramatanga, to keep opening that light, the window  
29 on what has happened to disabled people and maintain a light to make sure that what has  
30 happened to disabled people, to Deaf people, to blind people, to people with mental health  
31 conditions, to people with neurodisabilities, in care and support doesn't continue to happen,  
32 that we all have great lives.

33 Many thanks to many people. It's the first time there has been a public hearing of  
34 this kind on this content. I really want to acknowledge again the witnesses, the courage, it's

1 a taonga that you have gifted us, that has been gifted to Aotearoa New Zealand. And we  
2 thank all survivors, he purapura ora, who are here in person, who have watched from a  
3 distance. Some have travelled a long way. Kathy, thank you for being here and thank you  
4 for sharing your story with Commissioners. Catherine, thank you for sharing your story  
5 through your art and thank you to the other artists who have contributed to the hearing  
6 space.

7 Thanks to supporters, to family, to those who have cared for survivors and the  
8 courage and strength which you all brought to that as well.

9 Thank you to Ngāti Whātua Ōrākei for keeping the place safe for us, for keeping it  
10 culturally safe, for the gift of your blessing, your aroha.

11 Thank you to all the staff at the Inquiry, lawyers, counsel, the well-being people  
12 who help keep everybody safe, the New Zealand Sign Language interpreters,  
13 stenographers, registrars -- apologies if I miss anyone, but there's a lot of work that goes  
14 behind the scenes to make this work and there's an increased range of logistic to get a  
15 hearing like this right, so thank you to everybody who's made it work and kept people safe  
16 through that.

17 Thank you to the Crown, Whaikaha, the new Ministry of Disabled People. It is the  
18 first time I think this organisation is stepping up and we give you the challenge to take what  
19 you've heard forward now and beyond the time that this Inquiry ends in a year's time.

20 Thanks to Ko Taku Reo for your contribution as well, and a final thanks to the  
21 waiata team and Tony for supporting us, supporting everybody's voices and coming behind.

22 Now, as this hearing closes, Ūhia te Māramatanga, we hope it opens up more light  
23 on the subject and it opens up a new world of enabling good lives for us all. Kaikarakia,  
24 thank you.

25 **Waiata He Hōnore and karakia mutunga by Ngāti Whātua Ōrākei**

26 **Hearing concluded at 5.03 pm**