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

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

TRANSCRIPT OF PROCEEDINGS

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Hearing opens with waiata and karakia tīmatanga by Ngāti Whātua Ōrākei

[10.07 am]

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

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

BRIAN KENNETH STABB

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

A. Absolutely not, no.

Q. Thank you and you are?

SUPPORT PERSON: Nick.

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

A. Mmm.

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

A. I do.

Q. Thank you very much.

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

A. I do, yes.

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

A. Uh-huh.

Q. And you have that before you as well?

A. Yeah.

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

A. Yeah.

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

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

A. Mmm-hmm.

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

A. Mmm.

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

A. Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. That was nine families?

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

Q. Thank you. Please continue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. I think we got to paragraph 36.

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

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

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

A. Yes.

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

saying, by the Official Secrets Act?

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

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

backgrounds?

A. Yes.

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

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

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

A. Mmm.

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

A. Mmm.

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

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

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

A. Yes.

Q. The whole unit physically moved?

A. Yes.

Q. Okay, thank you.

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

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

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

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

A. Yeah.

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

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

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

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

Q. If we take you back to paragraph 50.

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

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

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

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

A. Yes.

Q. - before they were sent?

A. Yes, yeah, they would be sent.

Q. Paragraph 52, thank you Mr Stabb.

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

overseas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. I think you were at paragraph 61.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. In villa 6?

Q. Sorry, in villa 7.

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

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

A. Villa 7, yeah.

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

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

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

A. Villa 7.

Q. Where it was unmodified?

A. Yes.

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

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

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

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

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

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

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

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

Q. Sorry, in modified?

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

Q. It's not necessary to restrain?

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

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

A. Nurses.

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

A. Yeah.

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

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

Q. Before your time?

A. Yeah.

Q. All right, thank you.

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

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

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

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

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

Q. Unsavoury?

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

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

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

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

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

Q. Thank you for clarifying that.

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, I recall Anna Natusch.

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

A. Yeah.

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

A. Yeah.

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

A. Not very well.

CHAIR: We can make it larger.

A. Oh yeah, I can read.

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

If we could move to paragraphs 91 and 91:

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

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

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

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

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

Q. You haven't heart of that?

A. I know that that never happened.

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

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

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

A. Yeah.

Q. That there was a connection between getting Ds -

A. Yeah.

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

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

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

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

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

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

CHAIR: Do you feel like taking a break?

A. I'd love to have a break.

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

Adjournment from 11.28 am to 11.53 am

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

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

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

A. Yeah.

Q. - in the unit.

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

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

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

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

A. How it would manifest?

Q. How it would manifest.

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

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

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

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

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

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

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

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

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

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

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

A. Yeah, yeah.

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

A. Yeah.

Q. Giving the Paraldehyde for smoking.

A. That's right.

Q. It wasn't your signature?

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

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

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

Q. Yes.

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

Q. Yes, thank you.

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

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

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

A. 114 sorry?

Q. Paragraph 114.

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

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

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

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

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

A. Are we talking about this era?

Q. After 1974.

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

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

A. Yeah.

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

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

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

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

Q. What was the purpose of such a drug?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

Q. - were the regular staff on at night?

A. No, no.

Q. We'll pick up at 126.

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

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

A. Yeah.

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

A. No.

Q. - that?

A. No, not at all.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

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

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

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

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

A. Yeah.

Q. Which you mentioned earlier?

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

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

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

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

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

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

A. Yeah.

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

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

then I took another job in Rotorua.

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

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

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

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

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

A. Yeah.

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

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

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

A. Yeah.

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

A. I was 25.

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

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

Q. You said there were nine families that migrated across to work in the unit.
A. Yeah.
Q. But seven returned.
A. Within a couple of years, yeah.
Q. Only if you can recall, having discussions with them as to why they were leaving, were they not happy?
A. It was usually the wives who got homesick. And I think maybe the hospital too, disillusioned some people.
Q. About what was happening in -
A. I remember the advertising for the positions, described a modern, progressive 400 bed hospital in the Manawatu, and it wasn't a modern progressive hospital, it was a nightmare.
Q. Okay, thank you for that. And can I just refer you, in paragraph 19 you refer to a resident being tied up in a laundry bag.
A. Yeah.
Q. Was that a regular practice that you were aware of?
A. Actually don't know. I mean I - I was relieving at that time when that happened and I don't - it was literally a week or so after I'd arrived in the country, and I couldn't believe it that this was happening, that this was going on and the response, the only response I can come up with when I was told that it was part of his treatment was to just keep letting him out, which I did whenever it happened.
Q. Thank you. I just had one other question, thank you. Mr Stabb, we've heard some evidence last week about, and the use of the word cages, the use of the word cages.
A. Cages?
Q. Cages.
A. Uh-huh.
Q. So we've - it's been described to us that there were some cages outside a unit where patients or residences would be walking across probably like a compound, probably a space no bigger than about a two bedroom room it was described to us.
A. Yeah.
Q. And it had wiring around it, a bit like where you'd - the spaces - an exercise yard. Do you recall that?
A. I can't imagine what that would be unless it was the maximum security unit where there were caged areas, if you like, for exercise, but there was nothing like that in the open side of the hospital. The same thing as there was - there wasn't such a thing as a padded cell and

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

Q. A disproportionate number of children?

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

Q. So 70 to 80% were Māori or -

A. I'd say so.

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

A. Yeah.

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

A. Nothing in 1974, no.

Q. Not in 1974?

A. No.

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

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

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

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

A. I think that's been redacted out.

Q. My apologies.

A. I'm rather glad you said it.

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

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

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

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

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

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

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

MS FINLAYSON-DAVIS: Certainly.

CHAIR: Just to get our next witness ready.

MS FINLAYSON-DAVIS: Certainly.

CHAIR: We'll be back in 5 minutes.

Adjournment from 12.36 pm to 12.44 pm

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

CHAIR: Yes, we've discussed that.

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

GRANT ASHLEY CAMERON

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

A. Good morning.

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

A. I do.

Q. Thank you very much.

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

A. Yes.

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