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

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| **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)<br>Ali'imuamua Sandra Alofivae<br>Mr Paul Gibson |
| **Counsel:** | Mr Simon Mount QC, Ms Kerryn Beaton, Mr Andrew Molloy, Ms Ruth Thomas, Ms Finlayson-Davis, for the Royal Commission<br>Ms Karen Feint QC, Ms Julia White and Ms Jane Maltby for the Crown<br>Mrs Frances Joychild QC, Ms Alana Thomas and Tracey Hu for the Survivors<br>Ms Moira Green for the Citizens Commission on Human Rights<br>Ms Susan Hughes QC for Mr Malcolm Burgess and Mr Lawrence Reid<br>Mr Michael Heron QC for Dr Janice Wilson<br>Ms Frances Everard for the New Zealand Human Rights Commission<br>Mr Hayden Rattray for Mr Selwyn Leeks<br>Mr Eric Forster for Victor Soeterik<br>Mr Lester Cordwell for Mr Brian Stabb and Ms Gloria Barr<br>Mr Scott Brickell for Denis Hesseltine<br>Ms Anita Miller for the Medical Council |
| **Venue:** | Level 2<br>Abuse in Care Royal Commission of Inquiry<br>414 Khyber Pass Road<br>AUCKLAND |
| **Date:** | 23 June 2021 |

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**TRANSCRIPT OF PROCEEDINGS**

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**MR MOLLOY:** No, ma'am, just acknowledging that it's a lawyer's dream and everyone else's nightmare when you drag two witnesses along and the lawyer does all the talking, so my apologies for that.

**CHAIR:** A rare luxury for the lawyer I might say, Mr Molloy. I'm just going to ask my colleagues if they have any questions. You are spared then from homilies and other things from us, and I'll just ask Commissioner Alofivae to close off your evidence.

**COMMISSIONER ALOFIVAE:** Ms Hall and Mr Dunbar, look can I just thank you on behalf of the Commission, exactly like our counsel said, Mr Molloy, for coming along this afternoon and answering to the very best of your abilities questions that could not have been comfortable in most respects and having to reflect back on matters that happened a very long time ago. We also want to be able to formally acknowledge the apology that you've now placed on record, and hope that all goes well moving forward.

**MR DUNBAR:** Kia ora.

**CHAIR:** Thank you. We'll take a short adjournment before our next witness or would you like to carry on?

**MS JOYCHILD:** GRO-C .

**CHAIR:** We will adjourn.

**Adjournment from 3.02 pm to 3.27 pm**

**MR MOLLOY:** Afternoon, ma'am, we've got Mr Soeterik in the witness box and his counsel is Mr Forster.

**CHAIR:** Good afternoon, Mr Forster, welcome to the Royal Commission.

**MR FORSTER:** Thank you ma'am. What I propose to do is have Mr Soeterik read his brief. If either my pace or his pace is too quick or too slow, please let us know. Once he's read his brief, I'll have a few supplementary questions.

**VICTOR FREDERIK WILLEM SOETERIK**

**CHAIR:** Thank you Mr Forster. Before we do anything else I'll ask him to take the affirmation. Mr Soeterik, do you solemnly, sincerely and truly declare and affirm that the evidence you will give before the Commission will be the truth, the whole truth and nothing but the truth?

A. I do.

**Q.** Thank you very much.

**QUESTIONING BY MR FORSTER:** Your name is Victor Frederik Willem Soeterik?

A. It is.

**Q.** You live in Napier?

A. I do.

**Q.** Your date of birth is GRO-C 1944?

A. It is.

**Q.** That makes you 77, doesn't it?

A. Yes, it does.

**Q.** Can I have you read from paragraph 4 of your statement please?

A. I am providing this statement to the Royal Commission into abuse in care regarding my role at Lake Alice between the years of around 1975 and 1977.

I have previously supplied two statements, the first was to Phil Roigard of the Investigation Bureau Limited for Crown Law dated 6 February 2001. Following that I sent an e-mail to him with some supplementary answers, that he requested.

The second was to New Zealand Police dated 12 January 2010 to Detective Inspector Doug Broom.

The third one was the Napier Police Station on 17 December 2020 to Detective Peter Boyd which was a video interview but I've not yet seen a transcript of that. Do you wish me to go through my qualifications or skip that bit?

**MR FORSTER:** Ma'am, I take it that they're not in issue, but maybe if he just continues on because the work history starts fairly quickly at paragraph 11?

**CHAIR:** I think so. Well, we have read your brief of evidence, and it will be made public on the website, so -- I have just again, nobody's reminded me, this is nothing to do with you please, nor you counsel, this is to be embargoed isn't it?

**MR MOLLOY:** Thank you ma'am.

**CHAIR:** So all I'm going to do is make an order that this evidence of Mr Soeterik is embargoed, that means not to be published until further order which is likely to be -- it will be after you've finished your evidence, it may be in the morning depending on when the transcript can be checked, but it will be put up on the website as soon as the embargo is lifted. Sorry I didn't do that at the beginning.

**QUESTIONING BY MR FORSTER CONTINUED:** As the Commission pleases. Mr Soeterik, I want to take you back to paragraph 4 because neither you or I read that. Can you read that please?

A. Generally a retired clinical psychologist but I still do a little clinical consulting work.

**Q.** Please read your brief continuously from paragraph 9 please.

A. I hold a masters of arts degree with honours, a diploma in clinical psychology, a diploma in social sciences and a diploma in teaching. I am a registered clinical psychologist and a member of the College of Clinical Psychologists, the Australian Society For the Study of Brain Impairment and a member of the New Zealand Psychological Society. I am also a foreign affiliate to the American Psychological Society.

Between 1972 and 1974 I was completing my master's thesis on hyperactivity in children. I was hired as an assistant clinical child psychologist at the Child and Family Unit at Manawaroa to enable me to research my MA thesis and to access subjects for my research.

**Q.** That was in 1972, wasn't it?

A. Yes. Starting at the end of 1972. I was clinically supervised by Dr Selwyn Leeks who at times also asked me to work with cases at the Child and Family Unit under his supervision. My work as a psychologist was supervised by Mr John Gamby who was the senior psychologist at Manawaroa. I worked at the children's unit so I could access clinical cases under supervision for my studies.

The Child and Family Unit is no longer active but Manawaroa, of which it was a part, is now known as Ward 21 of Palmerston North Hospital, MidCentral. At that time the Palmerston North Hospital Board and the Horowhenua Hospital Board were beginning to amalgamate. I was employed by the Palmerston North Hospital Board as Manawaroa was a part of that and situated at Palmerston North Hospital. This is now called MidCentral DHB.

By the time I finished my master's thesis at the end of 1974, I had a bachelor's degree, a postgraduate diploma in teaching as well as a teaching certificate and at that time I had been teaching for primary schools for five years. I started to look for further training opportunities in clinical psychology. By about 1975 I was being paid as a clinical psychologist.

I visited, at Dr Leeks' suggestion, Lake Alice between about 1975 and 1977. I was to visit and learn at Lake Alice to supplement my learning and experience in my role as a psychologist at the children's unit at Manawaroa by Dr Leeks. Dr Leeks ran the Child and Adolescent Unit, the unit, at Lake Alice, as well as being the child psychiatrist at the children's unit at Manawaroa. I was back at Manawaroa full-time by 1979.

When I was at Lake Alice, I only visited the Child and Adolescent Unit and would attend there on a 1/10th basis, that's a half day week, which would include the travelling time from Palmerston North to Lake Alice and back again. Initially I would attend Lake

Alice on Friday afternoons. This was later changed to Wednesday afternoons. I was never employed by Lake Alice.

By 1976 after I had failed to pass the oral exam for the diploma in 1974 -- at the end of 1974, so I enrolled at Massey University for a diploma in clinical psychology which was then on offer by 1975. I passed the diploma in clinical psychology exams as a foundation student for that degree. I undertook this qualification to upgrade my status from assistant to full-time clinical psychologist. In 1974 I had failed my first attempt but after another year I graduated and received a diploma in clinical psychology officially in 1977. During my second attempt, I received more direct supervision and training opportunities.

Prior to being awarded the diploma in clinical psychology in 1977 I was already working full-time as a clinical psychologist with my other qualifications and experience regarded as being the equivalent and sufficient for the then advisor to the health ministry, Mr Ralph Unger.

By 1978 Mr John Gamby retired at the end of that year and I became eligible to apply for the senior position at Manawaroa. This led to a change of focus for me in the roles and responsibilities.

Between 1979 and 81 I was the senior psychologist at Manawaroa and then between 1981 and 1992 I was the principal clinical psychologist for the Hospital Board, so I had all kinds of jobs outside of Manawaroa at that time.

On 14 December 1990 I was awarded a diploma in social science in psychology.

I then started to develop -- sorry, to visit the Kimberley Psychopaedic Hospital in Levin for staff training, supervision and teaching and programme design. At this time I also began to research at the Child and Family Unit, the incidence of premature infants who presented later in life at the child unit as well as adopted children as both were statistically over represented.

In late 1972 and early 1973 I was also the secretary of the Massey University Student Association whilst I was studying. We were told then that the Manawaroa Psychiatric Unit was desperately short of staff to cover some late shifts. As students we spoke amongst ourselves and we supplied some students to do this. It was in this context that I then met Dr Leeks. He was one of the three psychiatrists at Manawaroa.

As a part of my training for the diploma in clinical psychology, which I was awarded in 77, I have had the experience working and assessing patients in adult psychiatry, rehabilitation, paediatrics, psychopaedics as well as adolescent psychiatric patients which were available for study at the Adolescent Unit at Lake Alice run by

Dr Leeks. I also acquired a senior clinical supervisor, Mr John Gamby. Mr Gamby was the clinical adult psychologist in the adult side of Manawaroa and for the Hospital Board.

At the children's unit in Manawaroa I became involved with learning to do intake interviews and began to do psychological testing for patients referred to me by Dr Leeks and the other child psychotherapist, Mrs June Scott. There was much to learn in several different fields of study, including psychopathology diagnosis and different kinds of psychological treatment modalities.

I was required to become familiar with drugs, treatments, diagnosis relating to psychiatry, a discipline we worked closely with in my field. I also learned about treatment, categories and theories for psychology and learned to do research and evaluate treatments. I would shadow colleagues such as Dr Leeks, Mr Gamby, also Dr Mason Durie and Dr John Weblin who were the other psychiatrists at Manawaroa. Dr Leeks was not often around, he would frequently evaluate and diagnose adolescent patients and meet with staff from places like Hokio Beach, Epuni Boys' Home, Margaret Street Girls Home, Porirua, Kimberley, Whanganui, Wanganui as it was called then, New Plymouth, Hastings and Lake Alice occasionally -- sorry, occasionally I did accompany Dr Leeks on one trip, for the purposes of training. Dr Leeks and I discussed the day as we drove back to Palmerston North.

Around 1975 at the request of Dr Leeks I began to visit Lake Alice first on Friday afternoons but this was changed to Wednesday afternoons. I would finish work at Palmerston North Hospital at 12 pm, car pool, travel to Lake Alice. I would have lunch there with the staff and then meet up with Dr Leeks, the unit staff and a large number of visiting staff to observe and to sit in on group therapy. At this time they had already had the beginnings of these large group therapy sessions involving more than 20 people.

The only links between the child unit patients at Manawaroa and those at Lake Alice was Dr Leeks.

Lake Alice had the only specialised adolescent unit in New Zealand until the late 1970s when one was opened in Christchurch. Some of the adolescents came from correctional establishments that Dr Leeks had visited. Some of them were referred from other places including outside the Manawatu and from the Child and Family Unit at Manawaroa.

The main contribution to the adolescent centre was carry out psychological testing, maybe sit in on some family meetings, some individual and group therapy. This was to contribute to some staff training. When I became involved at the unit, I had a chance to

observe group therapy and then family therapy.

I really did not have any specific patients, but on one occasion I carried out a therapy on a one-to-one basis. For example, I was asked by staff to help them deal with a case of a young boy in the dental unit. The staff could not contain his panic at the dental unit even with drugs. I did a demonstration of an in vivo desensitisation. This involved getting the patient familiar with the dental procedures such as injecting an apple, role playing the dentist, he role playing the dentist for me, familiarising him with the equipment, and making it fun. It was successful. This was the only one-to-one therapy I can remember. I cannot now exclude that it might have happened on one other occasion but it would have been the exception rather than a regular practice.

When I was at Lake Alice I was not responsible to anyone. However, I would check up on what I was seeing and learning with Dr Leeks.

I recall that educational psychologists would come and have a look at the adolescent group therapy at Lake Alice. Most of us as visitors had no pre-ordained role in the unit itself. I do not recall a psychologist being on the staff at Lake Alice Adolescent Unit.

The typical age range of the children at Lake Alice was approximately 10 to 16 years of age, although I am not 100% certain of that. I do not know the children's medico-legal status whilst they were at Lake Alice. There were around at any one time 14 boys and about six girls as a rough estimate.

The boy's villa when I first met Dr Leeks was originally in villa 8 because the inpatient numbers grew so fast, the boys had to be moved from adjoining villas 8 and 10 to villa 11, which was a larger unit or villa. Upstairs there were two seclusion rooms, though I never saw staff lock up anyone in those rooms. The girls stayed at the women's unit which I think was number 14 from memory.

From my memory the staff spoke about seclusion. I asked them about it and I recall thinking from their answers it was excessively long but I do not recall how long it was. One concern which was expressed to me by the adolescent patients was in relationship to being locked up when they misbehaved.

So I suggested the use of shorter periods of seclusion rather than these long periods. I also suggested the option for kids to take themselves into the room if they needed some time out for themselves to voluntarily unwind.

To my knowledge, some of these adolescents at the Lake Alice Unit had histories of absconding from various places prior to their admission at Lake Alice, but were again

starting to exhibit some of this behaviour. I do not know why the children were being moved from one institution to another.

By the time the children got to Lake Alice, they had either aggression problems, were running away or exhibiting sexual acting out. From a psychiatric perspective they may have exhibited all kinds of hallucinations and delusions which, with hindsight, could have equally been the symptoms now seen typically in Post Traumatic Stress Disorder and other disorders which we now consider important. I have only a vague memory of two children absconding from the unit. I do not know why they ran away.

I think from the -- the most successful form of treatment at the time was for children to be away from the traumatising situations they had been experiencing prior to arriving at Lake Alice. Some of the units the children came from were also both traumatising and containment orientated.

At times I had the impression that some of the kids were just badly behaved rather than having a psychiatric illness. Within the diagnostic categories that we now have we have more tools for better diagnosis. For example, there is a study called the ACE or the adverse childhood events study, where ACE scores predict from a range of 10 criteria and the more criteria which pertains to a child that they had in their early life as an adverse experience, the more likely they are to have certain negative life experiences, and these are long lasting.

I think that if the children who came to Lake Alice had stayed in State care it would have been clearer that many of the negative long-term effects were due to their care situation. If diagnosed differently as mental disorders and diseases, it follows, in my thinking, that physicians would use their medical tools and the knowledge that they had available at the time and do something about it.

I have very little knowledge about the consent procedures at Lake Alice at that time. Towards the latter part of my time at Lake Alice, however, this was an increase of meetings happening between families and staff. I never attended them but I was aware that they were happening. I have not heard about children being moved to the maximum security unit, nor have I heard of external children being brought into Lake Alice from places such as Kimberley for the treatment that were not actual admissions.

I formed the opinion over my time at Lake Alice that its history as a maximum security unit for the criminally insane left a legacy that biased its later role to be more coercive. The staff originally overlapped to some degrees the procedures that were being used or trained to use and were subsequently applied adolescents, particularly around

containment.

In those days psychiatry was less advanced and lessen lightened. There were less diagnostic frameworks available and less effective drugs.

I never observed restraint jackets being used nor ever saw restraint jacket.

I never observed chemical restraints like Paraldehyde or other tranquilising drugs like Chlorpromazine being used but it had been reported to me that they had been used. I never saw electroconvulsive therapy administered at Lake Alice but I was aware that it was being used.

Because of my background in teaching, I said that it seemed wrong to me that containment was preferentially used. I suggested to Dr Leeks about getting school teachers for the children as this would channel more positive and constructive behaviour. That suggestion was adopted.

I observed there were some tension between the more progressive staff on the one side and the more conservative staff on the other. I recall once having lunch with someone who told me that other staff had put sugar in the petrol tank of one of their group's cars as some form of revenge for expressing more progressive options than restraints.

The charge nurse Dempsey Corkran eventually tried to alter the mix of personnel to get more progressive staff at Lake Alice.

Being present at a sample of treatment for demonstration purposes or for learning about such treatment in no way represents what I personally or as a psychologist think of medical procedures nor whether I would endorse such a treatment or not.

**Q.** I think you might have skipped a page, did you go from page 8 to 9 or page 8 to page 10?

A. Sorry, yes.

**Q.** If you can start please at the top of page 9, paragraph 52 please.

A. Thank you. The buildings at Lake Alice were all stoney grey concrete. The place was devoid of colour. There were grounds but not gardens. The maximum security centre was the central building in which the criminally insane were kept. The surrounding villas where the children were was generally six to eight bed units. They were grey concrete. The doors were all lockable. The infrastructure had largely been set up as a restraint and containment place.

Looking back I think the unit was quite strange. Some of the children in the unit had problems with the criminal justice system while others had noticeable psychiatric problems. Not many had clear-cut psychotic disorders. In some ways it was a hell of a place for disturbed adolescents amongst disturbed adults. It was not the best environment

for them in my view.

Overall, it was a bad idea to create an adolescent unit with a therapeutic focus at Lake Alice. It would have been better -- it would have been a lot better to have a stand-alone unit closer to support networks, educational opportunities, recreational opportunities and further away from what had been at Lake Alice.

I got along with the patients at Lake Alice, some of whom later became adult patients of mine at my private practice prior to my retirement.

At all times I was operating as a guest visiting staff member at Lake Alice and did not have control over programmes, nor of therapy nor of staff. I did manage to make positive contributions and suggestions, such as starting a school for the children at Lake Alice and have them go out on an adventure training like the Mangatepopo Outdoor Adventure Camp, which was the Graeme Dingle camp. These suggestions for improvement were communicated to Dr Leeks. It was the responsibility for Dr Leeks as to whether he wanted to implement them and he seemed receptive to those suggestions.

At no time have I ever personally introduced myself as a doctor to anyone, nor to my knowledge was I ever presented as a doctor or a psychiatrist to anyone at Lake Alice, or anywhere then or since. I've always been Mr Soeterik. My unusual name makes me more memorable. At no time have I ever decided for any doctor how to treat people medically with drugs or ECT or any other intervention. I would only be held accountable for psychological treatments, goals and methods.

Would you like me to repeat --

**Q.** Yes please, keep reading continuously please.

A. Being present at a sample of a treatment for demonstration purposes and for learning about such treatment in no way represents what I personally or as a psychologist think of a medical procedure, nor whether I would endorse such a treatment or not. Sometimes doctors would demonstrate their treatments or skills of a craft for teaching purposes from a position of their expertise. I have had the privilege of watching other medical treatment procedures from other doctors over the years.

I did not conduct any private psychotherapy sessions with any adolescent boy or girl. By then I was not trained enough for that nor was there enough time of what would remain of an afternoon to even contemplate such a thing. It requires continuity to form a good therapeutic relationship.

In my most recent Police interview I was asked my opinion on the staff and their reported thinking that it was a good unit and the patients thinking that it was a bad unit.

This reflected the predicament of the adolescent children who found themselves being there was inherently unpopular. Some patients benefitted from Lake Alice. Some staff genuinely liked helping people.

I originally sat in on group sessions by virtue of my role as an observing student. I watched Dr Leeks lead the group discussions. Group therapy sessions had up to sometimes 30 people. Two years after starting there I sometimes attended as a co-therapist to the charge nurses for group sessions as I was more experienced than others and then but only in the absence of Dr Leeks.

I never ran the group sessions. I only ever sat in on them. I was not paid by Lake Alice, I had no organisational brief to run those sessions. In my e-mail to Philip Roigard, the first interviewer, I said initially I was a co-facilitator and later led them. I think I was mistaken when I said that, it just doesn't make any sense looking back.

The group therapy sessions included both boys and girls together. Besides adolescents, the groups also consisted of interested adults who were keen to study and learn from the groups and the methods used. These adults included assistant clinical psychologists from the hospital, Manawaroa, trainee psychologists from Whanganui as well as nurses, trainee nurses, and child psychotherapists.

Generally Mr Dempsey Corkran would be present, two or three psychiatric assistants, Dr Leeks, visitors like myself as well as other visitors. There were a lot of people in one room.

The groups were large. I later learned that seven or eight is a big group but there would have been 20 or more kids in the room, plus the adults. I think the atmosphere in group therapy was very tense, because nobody wanted to speak. In group therapy, children could speak about anything and everything. The children never spoke about ECT during sessions. I do not recall children being shoved to speak or answer any questions from Dr Leeks or myself during these sessions. Dr Leeks usually was silent.

I thought group therapy was a waste of time because it was too big and unwieldy.

I as well as staff and visitors would observe Dr Leeks running group therapy with the adolescents. Dr Leeks would demonstrate how he would do group therapy which was unusual for that time.

Staff, including myself, would be encouraged to participate with the group therapy sessions asking questions and following up on answers or sitting out in silence. After the sessions some staff sessions would follow, there would be discussions about tactics, techniques, and the theory of group therapy as well as discussions about individual patients

but usually I was not there because I was on my way home.

There was usually not much time for anything else as I would car pool back to -- by 5 o'clock to be in Feilding where I was living. I often would give Dr Durie a ride home in my car.

Dr Leeks told me that when he had been doing his training in London he had also been studying Freudian psychotherapy. He said he would sometimes spend a whole hour in a session and nothing would be said but he may take some notes.

When we eventually had group therapy with the children at Manawaroa -- but that should have read at Lake Alice -- we would keep it as a group -- sorry, with the children at Manawaroa we would keep that group to a maximum of six. The sessions would also be more structured than those at Lake Alice. But they only lasted about six meetings and then they were cancelled.

I offered to introduce some psychological testing. This was partly an outgrowth from Manawaroa where John Gamby was very keen on giving everyone a MMPI or a Minnesota Multiphasic Personality Inventory. It was an adolescent version of that. I suggested we combine that version in teaching staff at Lake Alice how to use or how to administrate it at Manawaroa. These paper and pencil tests were administered by staff and I would analyse the data later. I would talk to Mr Gamby who was an expert about the interpretation because I thought at the beginning there were too many diagnoses of schizophrenia. Looking back there were many people who had what we now call adverse childhood events and other sorts of things that had come to light with the DSM 3 which came in 1980.

Many of the children had been exposed to various types of abuse and suffered from what was at that time a not yet diagnosis of PTSD. People would have intrusive recollections triggered by different things and then would report what seemed like symptoms of delusions and hallucinations and would be badly diagnosed with schizophrenia. Now we would understand them to be trigger events relating to trauma. A commonly used drug treatment that was available to Dr Leeks was Stelazine, especially for those he diagnosed as schizophrenic. I think the limited drug options until the 1980s or 90s was a problem for many psychiatrists at that period.

PTSD did not become well-defined until after 1980 with the diagnostic statistical manual version 3 of the American Psychiatric Association. People then had a frame of reference and therefore could look for alternative ways of dealing with it. Between 1980 and 1992 newer drugs became available such as more antidepressants. The handbook of

understanding and treating traumatised children was published. Dr Bessel Van Der Kolk was one of the more leading experts, looked at the neuropsychology and physiology of PTSD and wrote a very influential book called The Body Keeps the Score. In chapter 2 of that book he explains his own experience of modern psychiatry when he was still a house surgeon at one of those large institutions. The modern thinking is to control the body not to be captured by the fight or flight hormones that analysed the memory to be able to be worked about.

I recall only one incident at Lake Alice with a patient being violent. It did not amount to anything at the end and was resolved at the session. Group therapy, however, can be confrontational. I do not recall who that person was.

As time went on the staff instituted more behavioural techniques away from the more containment oriented approach towards a more positive ways and means of achieving behavioural change.

I am aware of an allegation made against me which states that I masturbated in group therapy in front of a young woman. I thoroughly deny that allegation, especially not with the people in the room.

I have never had any allegations made against me in the 50 years since Lake Alice, nor in any other of my practices. I believe the woman who said I did -- I believe the woman also said I did something similar when I saw her in therapy by myself. I do not recall ever seeing anyone in therapy by myself at Lake Alice. I can only remember doing the one-to-one therapy with the little boy in the dental unit. That was observed by other staff. It was not my role to give anyone one-to-one therapy there. Therapy is usually ongoing and there would be some record if it was ongoing including in my memory.

ECT remains an acceptable treatment for depression. At that time ECT was also used for schizophrenia, sometimes for obsessive compulsive disorders. As some of the adolescents in the unit had been diagnosed with schizophrenia, ECT would have been considered as an appropriate treatment for them at the time. It was not an appropriate treatment for anything else.

Prior to going to Lake Alice, I had a look at the standard ECT machine at the Palmerston North Hospital at Manawaroa. The standard ECT machine have a high voltage dial and it had a button that would deliver a pre-timed discharge of the electrical current. The ECT machine at Lake Alice looked like a standard ECT machine. Dr Leeks showed me his version of which had a rheostat, the voltage dial which could be turned up. I asked Dr Leeks how he knew the voltage, what voltage to differ. He said by turning up the dial

from zero to maximum, with the words to the effect "from zero to whatever". I do not know what the maximum voltage of that machine was.

Dr Leeks' application was bitemporal, meaning two temporal lobes, whereby the electrode placed on each temple rather than both electrodes placed on one side which is unipolar.

I never witnessed ECT at the unit. I did at Manawaroa but only once on one adult patient. When the unit was initially in the two buildings side by side, which was 8 and 10, ECT was administered in one of those buildings, but I never saw the room.

I do not remember any meetings with Dr Leeks or staff to discuss patient treatment. Later staff began to meet with families to discuss treatment, but that was all that I can recall.

I was not aware of the children's view of ECT as I never did any individual work with them. Though, through talking to people, I learned they were very fearful of them. I never heard of staff other than psychiatrists administering ECT. I did not think they were licensed or had access to the machines, that's the nurses.

I am not certain whether -- when ECT was given. It must have always been given when Dr Leeks was around. He was often at Manawaroa or on the road, so ECT may have been given in the evenings, because he had initially a house at the hospital grounds. I cannot recall if there was a particular day that he attended the units. He may have been there on a Friday as that was -- I was there initially(sic).

I do not know if Dr Pugmire, that's the medical superintendent supported Dr Leeks' treatment techniques. I am aware there is a letter from Dr Pugmire about a meeting with Dr Leeks regarding the removal of an ECT machine. I do not recall attending that meeting like that at all.

Paraldehyde is a painful injection to receive. I see how its administration may have been seen as "torture", quote/unquote, if it was perceived as a threat in a punitive climate.

Paraldehyde was like a chemical strait jacket. It's a form of medical subjugation as more commonly used before I started at Lake Alice. The nursing staff could administer Paraldehyde initially in the absence of Dr Leeks on a PRN basis. That's a medical abbreviation pro re nata, not scheduled. This would be charted in advance as being available on a needs basis but would have to be noted and countersigned by Dr Leeks, subsequently, to sign the medical charts for its administration. I thought there were better alternatives. I did not agree with the use of Paraldehyde on adolescents.

Psychologists in New Zealand cannot prescribe or administer any medication to any patient. In many medical organisations a doctor can and does prescribe medication. If he is not present these can be charted to be as and when needed so other trained staff can administer it. I can imagine this was the case at Lake Alice. I cannot recall Paraldehyde being administered to patients but I heard from staff and patients that it was an extremely painful injection to get.

I think the staff I met at the Lake Alice Unit were quite caring. It is my impression that these staff would look upon the situation and try to make it better. They would generally implement many of the discussions I made.

Dr Pugmire was the medical superintendent at Lake Alice during this time. I do not ever recall him coming to the unit. Dr Pugmire and I had a relationship that was cordial. After my time at Lake Alice, I was involved in the teaching and training of his daughter Olena as the clinical psychologist.

Dr Siriwardena was a medical doctor at Lake Alice, the chief nurse was Tony Quinlan I think. And I believe that Tony Quinlan was instrumental in having the unit shut down.

During the time I was working at the unit, the nursing staff that I remember only were Oma Cribb, Brian Stabb, Denis Hesseltine, Dempsey Corkran who was in charge. The teachers were Anna Natusch and Sheila Daly. I did not ever really meet the afternoon or the early morning shift, so I don't know anything about that.

Dempsey Corkran chose to staff the unit with Denis Hesseltine from the Salvation Army. Two nursing sisters called the Ormsby sisters from Parewahawaha Marae in Bulls. He also recruited Brian Stabb who left later to become a nursing tutor. The people that had been selected by Dempsey had a softer side to them, unlike many of the other staff at Lake Alice Hospital. They had a greater affinity for the child rather than hammering a diagnosis.

The nursing staff at Lake Alice were a combination of trained psychiatric nurses, many of whom were staunch members of the PSA, small numbers of psychiatric assistants and towards the end of the 1970s, the first of the comprehensively trained nurses.

I do not know if the school operated well or not. I thought the kids needed a stimulating and structured environment. I was not aware of the reward system at Lake Alice.

I can recall an educational psychologist called Professor Don Brown from Victoria University. He was interested in children with special needs. He also visited Kimberley Hospital and training school and taught at Victoria. I never had a discussion with Professor

Don Brown about Dr Leeks' methods.

I do not recall children complaining about staff treatment. No child at Lake Alice ever disclosed allegations of mistreatment to me. Though I did not see the children on a one-to-one basis. If I had a major concern about what I noticed I would raise them directly. I thought that if I could make a positive suggestion, I would raise this too. Sometimes later these suggestions were enacted.

Overall I do not recall any of the staff acting in an inappropriate way. I have seen some staff at other places being unnecessarily rough but this was not something I saw at Lake Alice.

Dr Leeks lived on the Lake Alice Hospital grounds when I first met him. I am not certain, but I think he did some work at Lake Alice in return for his accommodation. I first visited him, his wife and three daughters when he was living there.

As far as I understand, Dr Leeks did his medical training here in New Zealand. I think for a short time he was a GP at Collingwood. Then he went on and did his training as a child psychiatrist in London taking with him three children and wife. To me this training seemed very Freudian as he had to undergo a training analysis of his own for about five years. At a non-Freudian myself, I thought that there were better more structured ways of doing things. I suggested to Dr Leeks that it would be good if he could give feedback to other psychiatrists and other psychiatrists could give feedback to him to create a more collegial supervisory system. So I remember, a side issue, that I delivered two papers to psychiatrists in 75 and 77, I just came for the paper and back again, so he was to follow that up, that suggestion.

**CHAIR:** Sorry, where did you deliver those?

A. At Lake Alice.

**Q.** So there were some form of group -- a group of psychiatrists who came together?

A. For that particular meeting, yes. I thought it would be leading to less excessive behaviours if people are mutually accountable to each other on equal footing.

**Q.** Do you remember how many psychiatrists attended? It's a long time ago I know.

A. Let me see. About four or five.

**Q.** Were they from all over the country?

A. Yes, one of them, for example, I remember was from Christchurch.

**Q.** Do you remember his name, his or her name?

A. Her, no, not 50 years ago nearly.

**Q.** So a female psychiatrist from Christchurch?

A. Yeah.

**Q.** Anybody else?

A. I think she must have been the one who set up an adolescent unit in Christchurch as well. Sorry, I can't --

**Q.** You can't remember the others?

A. No.

**Q.** How many of these meetings were held?

A. Two, one in I think 75 and one in 77.

**Q.** And did anything come of them? Were there any papers published or any report made of the meetings?

A. I don't know the answer to that question.

**Q.** Thank you.

A. I liked Dr Leeks, however I did not always agree with his methods. I did not witness any untoward treatment, including applying ECT electrodes to any parts of the body beside the head. I had heard about this occurring, but I am not sure where from. I asked Dr Leeks about it and he told me he was investigating the use of faradic shock treatment on adolescents. He brought me an article from a British journal regarding faradic shock. Faradic shock treatment involved the use of powerful electric shocks to induce behavioural therapy by punishing certain behaviours. I understood from the context of our discussion it was not always applied to the head as with ECT. To me this was a type of Aversion Therapy and acts mostly to suppress behaviour temporarily.

I told Dr Leeks I did not feel comfortable with the idea of faradic shock. I said to him this was not a treatment, it was punishment and I would not be visiting Lake Alice if this was his way of working. He did not agree or disagree straight away but as far as I understood it it stopped.

Around about this time there was the movie One Flew Over the Cuckoo's Nest and I asked Dr Leeks if he used unmodified ECT as well. He said that he preferred to give adolescents unmodified ECT because ECT shock leads to memory losses, including the loss of the memory of the treatment. Dr Leeks said that modifying the adolescent with a general anaesthetic makes the adolescent sicker than the actual ECT treatment itself. I think this conversation occurred around about 1975. I did not think this was the best way to achieve positive behaviour change and I still do not think so. My belief, and I have no proof either way, is that he did this prior to my involvement with the boys in villa 11 and that it had ceased somewhere between 1974 and 75.

I do not have any views regarding the methods of Dr Leeks regarding modified or unmodified ECT as I was not allowed to do that sort of thing in my role. I am a curious person so I would argue with him about the punitive effects of faradic shock.

At Manawaroa people would mostly get a muscle relaxant like a Valium or Diazepam and sometimes there would be an anaesthetist to give a very light anaesthetic. The electrodes would be placed either laterally or bilaterally. Some say if the electrodes were placed unilaterally there would be less memory loss.

Dr Leeks once asked me to sit in at the unit when he gave or administered a drug called Psilocybin to a girl who was about, in my estimate, 16 or 17 years old. This was not a truth drug and I believed it to be a waste of time. It's just making a comeback again. His reason for administering the Psilocybin was to assist her to release, or as we call it to abreact some memories for sexual abuse she had experienced as a child. I was sceptical then and I remain sceptical about this now. I think it was administered by injection but I am not 100% sure. From what I could tell she did not connect with any memories, if there was anything to connect with, so there was nothing for Dr Leeks to work with. This kind of treatment is currently making some sort of comeback but under much more controlled situations.

I went to Lake Alice on the understanding with Dr Leeks that certain things would happen, like the use of more positive reinforcements methods and the introduction of the school for the children. I believe -- and the availability of the swimming pool as well. I believe that Dr Leeks did change his style progressively and I thought he was listening to others and that treatment improved. At the time he had some support for his methods from other child psychiatrists, though child psychiatrists were incredibly scarce as they still are now.

From what I recall, part of why Dr Leeks left Lake Alice to go to Australia was because he and his wife Priscilla had a falling-out. He then established -- he then had established a relationship with a nurse at Lake Alice called Yvonne Howe. She in fact was, if I may digress for one moment, the nurse who he asked me to work with for four sessions or five sessions at Manawaroa for the smaller groups there, so she went to model it behind a one way screen.

**Q.** Sorry, was she being analysed or was she part of your team?

A. No, no, she and I were co-therapists, so she would learn some of his skills, but we were both being supervised behind a one way screen.

**Q.** By Dr Leeks?

A. No, by a lot of other senior staff, some other psychiatrists, psychologists, some other people in training. But it sort of didn't last long, it was a failed experiment.

Anyway, he established this relationship and she later became Yvonne Leeks and I understand she still is his wife living in GRO-C Melbourne. GRO-C He had tried moving this new love of his life into the house where he and Priscilla were living. She did not want that to happen. I don't know what occurred after this but he may have gone to try his luck in Australia or that things got too hot for him in New Zealand, though I am not sure, this is just what I heard.

**QUESTIONING BY MR FORSTER CONTINUED:** Mr Soeterik, you've done a good job reading your brief. Would you like to have a quick sip of water, I've got a few follow-up questions for you.

A. Okay.

**CHAIR:** You've got about 5 minutes, Mr Forster, if that's all right.

**QUESTIONING BY MR FORSTER CONTINUED:** Yes, ma'am, I should hopefully be quick. You mentioned the one way glass mirror, where was that?

A. They were in quite a few offices that we used as offices at Manawaroa itself.

**Q.** Was it at Lake Alice?

A. No.

**Q.** Paul Zentveld has provided some material for this Inquiry.

A. Yes.

**Q.** And you've seen a statement that, or excerpts from a statement that he provided?

A. Yes.

**Q.** One of the suggestions made is that you were aware that if people didn't cooperate in group therapy, by expressing their feelings or stories, that you were aware that people might face punishments as severe as ECT. What do you say about that?

A. I had no awareness of such a thing at all and neither did I ever suggest to anybody they should be given ECT if they didn't speak up.

**Q.** Were you taking group therapy sessions at Lake Alice?

A. One or two, so we're talking probably over two years, I'd say 80 or so sessions, but Dr Leeks was not always there and occasionally Dempsey Corkran wasn't there either, so I would fill in so there was continuity, but generally speaking, no.

**Q.** Anna Natusch has also provided information for this Inquiry, hasn't she, and you've again seen excerpts from her statement, haven't you?

A. Yes.
**Q.** Did you interrogate her when she came to work at Lake Alice as a teacher?
A. To the best of my recollection, she and Sheila Daly were introduced to the staff at Lake Alice at the time on a morning tea and said hello, introduced myself, and that was the last time I actually spoke to my recollection to Anna Natusch ever.
**Q.** She says that she tried to speak to you, paragraph 58, about what was going on in terms of bad things at Lake Alice. Do you have any recall of that conversation?
A. None whatsoever.
**Q.** Ms Stuart has also given a statement to this Inquiry, again you've seen excerpts from her statement, haven't you?
A. Yes.
**Q.** Were you involved in administering Paraldehyde?
A. Paraldehyde.
**Q.** Paraldehyde, sorry about that.
A. No, as I've said previously, I'm not licensed to and don't wish to be licensed to administer medical treatments to anybody.
**Q.** That's because you're a psychologist?
A. Correct.
**Q.** Whereas a psychiatrist is a medical doctor?
A. Correct.
**Q.** They can prescribe?
A. Correct.
**Q.** Right. Now in terms of solitary confinement, another comment she has is about excessive solitary confinement. What was your view, you've already mentioned it briefly, about solitary confinement?
A. Well, I'm trying to get the staff, the two solitary confinement rooms were attached in the big room to which we sometimes had group therapy, and I tried to convince them that if you have little children and you put them in a time-out situation, that the appropriate time would be multiplied by the age of the child, so 5 minutes for a 5 year old is one hell of a long time, 14 minutes for a 14 year old is equally long to give them. But so the first thing was that any long-term hours, and they may well have done before I became aware of it, I tried to change that practice, or suggest that they do.

And the second thing was that I said you should not use the keys and lock people in, you can be put on a naughty corner like in -- but not under lock and key which is a

completely different connotation. So I suggested that people could open the door themselves, go in, shut the door if necessarily, learn to soothe and contain themselves, and then come out whenever they felt ready.

**Q.** At paragraph 50 she said she had two outpatient follow-ups at Manawaroa. She could have easily have had that, couldn't she?

A. That would have been the group of four or five that I was talking about with Mrs Howe, Yvonne Howe.

**Q.** And she's correct that would have been behind a one way mirror?

A. There was a one way mirror there, but it was policy and procedure at Manawaroa to collect the patients on their way to such a room and tell them that like a Vodafone call, this call is being monitored, that this would be monitored, and by whom and also what the purpose of it was, which was to look at staff and staff training.

**Q.** One of the concerns that she has about this group therapy at Manawaroa is about a real invasion to her privacy. Just expressly tell us what safety, and I know we're talking about the 70s, but in terms of privacy, what was the procedure?

A. Well, the procedure was by asking people to become aware of the fact that we were going into a room in which there was a mirror behind which in the next adjoining room would be other people, those people would be there to try and help and train and supervise us rather than anything about the patient. And everyone was asked their consent, whether they would be okay with that or not. Now unfortunately the selected people were not selected by me but they came via Lake Alice and Yvonne Howe took them to Manawaroa, so I met her for the first time.

**Q.** Finally, Malcolm Richards has also given a statement to this Commission, again you've seen excerpts from his statement?

A. Yes.

**Q.** He raises the concern again of ECT as punishment for not co-operating in group therapy?

A. Yeah.

**Q.** What's your comment about that?

A. The same as before, I personally was never ever aware of a list putting people on ECT for bad behaviour. I would have said the same thing to Dr Leeks then, had I known about it, that I would not come if that was the case. Because as my understanding of medical treatments go, you get a diagnosis, you select the appropriate treatment that goes, that's appropriate for that diagnosis, and you may get a course of ECT that it's not one treatment, usually sort of like between five and eight in the series with the suitable time interval in

between you give the patient to recover, number one, and number two is, to see if the symptoms which were being treated would abate, lessen or whether they would still be as strong as before. So if I thought what he claims then I would have said either you change that and you have ECT for the purposes of treatment, or I don't come.

**Q.** Finally, one last question, it occurs at footnote 1 of his statement. He says that he's aware you were an ACC assessor for one period and you turned down ACC claims. Have you ever been an ACC assessor?

A. Never been one or paid as one.

**Q.** You have been funded for some of your work in private practice by ACC?

A. Absolutely.

**Q.** Thank you, if you remain there and answer any questions.

**CHAIR:** Yes Mr Molloy.

**QUESTIONING BY MR MOLLOY:** Thank you ma'am. Mr Soeterik, you were at Lake Alice between about 1975 and 77, is that right?

A. Somewhere in that ballpark, yes.

**Q.** And you met Dr Leeks some years earlier than that at Manawaroa?

A. Yes.

**Q.** Around about 72 or 73?

A. And 1972.

**Q.** You'd known him for some time by the time you got to Lake Alice?

A. I did.

**Q.** And over a period of time you had a lot of conversations with him, did he become sort of a bit of a mentor to you?

A. Yes, first clinically and professionally, so he helped me with my thesis, although that was not entirely a happy marriage because he came from a psychiatric perspective rather than a psychological perspective.

**Q.** He became a bit of a mentor to you over that period of time, he was somebody who would talk to you and you would talk to him?

A. I mostly talked to him, although when he watched me in action with some of the patients he assigned to me at Manawaroa, the child unit, sometimes he would make some confrontative comments like, for example, once I saw one of my first patients who he then asked after we had a session finished, who told him we had a really good lesson, and he said "Are you sure you're training to be a therapist or are you still a teacher?"

**Q.** When you started going to Lake Alice, what did you think of the fact that it was adjacent to

the adult forensic unit?

A. Well, it was a little bit away from there but nonetheless on the same grounds, I thought it was a bad idea because every institution develops its own culture and cultural practices to which they ask the staff to subscribe and perpetuate, and I thought that was a bad thing to do because adolescents, however difficult they might be, still require a different setting in order to grow up and not be captured forever.

**Q.** How would you describe the culture among the staff at the Child and Adolescent Unit when you got there?

A. Well, I'd like to first point out that the staff comprises really of three lots, there's the sort of midnight shifts, there's the shift sort of after 5 o'clock or whenever they knock off and the daytime staff, so the staff I actually have I knew was only the daytime staff. What happened --

**Q.** What would you observe about the culture of the staff you observed?

A. I thought they were generally -- the daytime staff were generally friendly and trying to do their best and trying to learn new stuff to advance the lives of the people they had care for.

**Q.** You describe some differences in approaches among the staff, how would you characterise those?

A. Well, initially is my understanding the staff were recruited from the general pool of staff at Lake Alice itself, so they weren't -- unlike starting up something which is brand new and selecting people specifically --

**Q.** So what were the ramifications of that?

A. Well, the ramifications -- this is my personal point of view -- is that in the first few years as even before I came in 75, so a good three years, he started, I think, the unit in 1971 or thereabouts. What it engendered, if there is untoward behaviour or unprofessional behaviour or bad behaviour or gross negligence or violence or whatever, then it leaves a legacy and it creates a second culture which is amongst the patients, because adolescents do what adolescents do best, they check up with each other about what's going on --

**Q.** So you observed the legacy of that culture while you were there?

A. I think so, I think they were people who had had bad experiences already before they came to Lake Alice, came to a similar sort of --

**Q.** I'm asking about the culture of the staff though.

A. The staff, yeah, well, I think that Mr Corkran tried to change the culture by introducing new staff at least during the daytime that I was aware.

**Q.** So what was he trying to achieve, what was it about the old staff that he was trying to

change?

A. I think like with the children, the petrol example, the old staff were not in favour of what he and Dr Leeks were trying to achieve and do.

**Q.** Which was what?

A. Do therapy! Create behaviour changes.

**Q.** So how were the new staff able to do that in a way that the old staff had not?

A. Well, with the support of Dr Leeks and Mr Corkran, maybe even from people like myself and from the new school teachers who were not you could say members, they tried to make slow and progressive changes one step at a time, one day at a time.

**Q.** What changed about the nursing practice?

A. For example, locking people up, for example using the leeway to have a PRN medication system in giving injections, for example like Paraldehyde when it wasn't warranted, because they're also human beings and they don't always like what adolescents do, so --

**Q.** So what did you think about Paraldehyde being administered to adolescents at Lake Alice?

A. I think it was not appropriate at all.

**Q.** Had you ever seen it at Manawaroa?

A. No.

**Q.** And you were familiar with the practice of the psychiatrists there?

A. Yeah.

**Q.** Dr Durie?

A. Yeah.

**Q.** I think there was another one you named?

A. Dr Weblin, John Weblin.

**Q.** That's right, and Dr Leeks as well?

A. Yeah.

**Q.** Were you aware of Dr Leeks using Paraldehyde at Manawaroa?

A. Never.

**Q.** Why do you think it was used at Lake Alice?

A. Well, it was used commonly, as I understand it, I don't have proof of these things, at, for example, the maximum security unit.

**Q.** I'm talking about the Child and Adolescent Unit, why was it used in that unit?

A. I don't know, because I wasn't always aware that it was to start off. I am deeply saddened to read some of these accounts from the survivors that indeed they seemed to say it happened as often as it did.

**Q.** The nursing staff confirmed it was administered.
A. Yeah.
**Q.** And what do you think about that as a practise for children?
A. I think it's sledgehammer tactics. Didn't approve of it at all.
**Q.** Did you ever glean from any of the children their reaction to the use of that kind of medication?
A. Not from the children, no.
**Q.** Who from?
A. I think from memory it was a staff member who told me about what they observed about the painfulness of the injection on the injection site, yeah.
**Q.** Why were they talking about that do you think?
A. Well, not all staff members who have to administer things on doctor's orders necessarily always agree with it, that would be my explanation.
**Q.** If it's administered PRN it's not on doctor's orders specifically, though, is it?
A. Technically it is and technically it isn't.
**Q.** Well, it's different from being prescribed, isn't it, that's the point I'm making, they have a discretion to use it if they think it's warranted?
A. It's got to be prescribed in advance.
**Q.** PRN means they have a discretion to use it?
A. And they have a discretion to use it.
**Q.** If they think it's necessary, and nurses did have that discretion and some nurses used it?
A. The question is really whether, and we don't have much evidence of this, whether the injections are after 5 o'clock, even after 1 o'clock in the morning, or during the daytime, and I believe --
**Q.** There's plenty of evidence that injections were given and the children at the time did not like them.
A. That's correct.
**Q.** And there's evidence that they were used often the threat of an injection was used to address behaviour and to promote some behaviour and prevent other behaviour.
A. I don't know about the threat part, but I mean I don't know about that, I have no recollection of that.
**Q.** You've spent some time in psychiatric units and I think they probably still have a coercive element about them now, but in the 1970s there would have been a considerable element of coercion present, even in a benign psychiatric unit, would that be fair?

A. It would be fair, and I think if you look at what happened in the 80s and the 90s, the large-scale demolition of institutions, psychiatric institutions probably suggests that it's difficult to change those inbred cultures and starting afresh with a different model might be the better way to go.

**Q.** So when you were involved with group therapy, what did the children used to talk about?

A. Nothing much.

**Q.** Why was that do you think?

A. Well, the first one I attended probably, which was an hour long approximately, would have been a brief introduction of the adults in the room and then it would be silence until the end of the group.

**Q.** And, was that always the case?

A. A lot of the time, yes, because this was Dr Leeks' model that he introduced as group therapy.

**Q.** And did you ever have a discussion with him about that?

A. I did.

**Q.** And what was the -- what were the points you were raising?

A. Well, he would bring up his own experience, for example, in his training analysis, that his analyst would actually simply sit behind him and say nothing maybe for an hour, sometimes just take notes, and occasionally if he choose to begin to discuss more, divulge more then eventually interpretations would happen. But I thought that given the developmental stages of adolescents that it was not terribly appropriate. I said so, but he probably did not agree with me on that point.

**Q.** And when you talked to him about the use of Aversion Therapy, what was the nature of that conversation?

A. Well, the Aversion Therapy I said to him if you use the machinery which is meant to -- which is a treatment machine as a punishment machine, then I made the offer not to actually go to Lake Alice if that was going to be the case, because I found that abhorrent and repugnant.

**Q.** Why was that?

A. Because I don't think punishment is a treatment.

**Q.** And roughly when do you think that was, was it before you started there or after you'd started?

A. Well, it was probably about 1974ish.

**Q.** So before you started going?

A. Yeah.
**Q.** And what did he say to that?
A. Well, first he parried my criticism really with bringing to work next day or the day after an article on faradic shock, and I read it with interest It must have been some British journal of experimental whatever it was, psychology and then I said to him but it's still punishment, and my learnings about punishment from my researches so far, suggest to me that punishment, if it does anything at all, will suppress -- in violent patients it will suppress violently, but it returns and it can often return with a vengeance.
**Q.** How did the subject come up, it was before you'd started there, why were you talking about punitive treatments at Lake Alice at that stage?
A. Well --
**Q.** Had you heard about what was going on?
A. I had heard from somebody, but I also asked Dr Leeks if that indeed was what he did.
**Q.** Can you remember who you heard from?
A. Not really, my mind is a bit --
**Q.** It's a long time ago.
A. -- fuzzy about that, because sometimes I visited him in a friendly fashion when he was living in his own house with his kids, we had walks in the grounds and identified trees and all sorts of things. Sometimes --
**Q.** There was a degree of knowledge about what he was doing, would that be fair to say, within the clinical community in Palmerston North?
A. Not that I'm aware of, no.
**Q.** So where did you get your information from, was it within the clinical community or from somewhere?
A. Probably from within Lake Alice.
**Q.** But this was before you started there?
A. Yeah, but that doesn't mean I was never there.
**Q.** You used to go out there?
A. I used to go out there on a friendly basis, sometimes I'd visit him, sometimes he'd say "I've got to go to villa 8" or something and go and do something there, so you'd hear things indirectly.
**Q.** So as far as you know, given the, ultimatum might be too high way of putting it, but given what you said to him, as far as you're concerned he didn't use that therapy after you started there?

A. Not that I was aware of, no.
**Q.** So when the --
A. It was an ultimatum.
**Q.** When the Magistrates Inquiry was convened and the hubbub that led to that in the second half of 1976, when that was all sort of blowing up, did you revisit that, did you talk to him about it then?
A. No, because I never heard any of the substance of that inquiry nor its findings, I'm blind to --
**Q.** Yes, but even before the inquiry there was a lot of press about it, were you blind to that, you didn't see any of that?
A. No.
**Q.** Really? Did you read the paper, did you watch television news?
A. I was busy with two babies, new house, two degrees, all sorts of other things.
**Q.** Yes, but you were visiting the psychiatric unit?
A. Yeah.
**Q.** Which was at the heart of a fairly substantial scandal at that time, whether it was substantiated or not is a different thing, but there was talk about it. So busy as you may well have been with young children, everyone can sympathise with that, doesn't mean that you don't hear what's going on, particularly when it relates to a workplace that you go to and it involves a professional person who you held in quite high standing. So you knew nothing about it?
A. No, I knew that there was an inquiry going on.
**Q.** About what?
A. I don't know.
**Q.** Really?
A. Yeah, Dr Leeks told me there was an inquiry going to take place. But I never heard what the substance of that was.
**Q.** Were you remotely curious about what it might have been?
A. Not about that, no.
**Q.** Why not? It seems very odd to be so lacking in curiosity about something that is so directly relevant to someone you've described as a bit of a mentor.
A. I didn't really think it was relevant to me at the time, given all the other things I was doing.
**Q.** How do you know it wasn't relevant if you don't know what it was about? You must have known what it was about, in a broad sense?

A. That's a good question. In reality the answer is I don't until I ask, it's true.
**Q.** Nobody at Lake Alice was talking about it in any sense?
A. Not to me, no.
**Q.** There was no concern about it?
A. No, not that people expressed to me.
**Q.** Or in your presence, lunch time scuttle, anything?
A. No.
**Q.** Nothing at Manawaroa Hospital?
A. I knew from Dr Leeks when he was at Manawaroa that it was taking place, but he never actually even told me what the outcomes were, what the scope of the Inquiry or what it was exactly about.
**Q.** I think you mentioned in your statement that the most successful form of treatment was for children to be away from traumatising situations. Do you remember saying that?
A. Yeah.
**Q.** So in what sort of traumatising situations were children getting away from at Lake Alice, just in a very broad sense?
A. I think many of the children came from a number of State institutions which I believe is also the subject of some of this Inquiry, but before they got there, you also have exposure, but these children experienced other traumatising situations, often at home, so -- and --
**Q.** You talked I think about the ACE tool?
A. Yeah.
**Q.** What sorts of -- you may or may not remember I don't know, but what sorts of things were recorded in the ACE?
A. For example, does anybody ever say they like you or want you, for example, if there's a parent who is in jail, for example, if mum beats dad about in front of the children, for example if there are alcohol and drug issues in the home, all sorts of things like that.
**Q.** Subjected to violence?
A. Yeah, subjected to violence, subjected to --
**CHAIR:** Just come closer to the microphone, you're drifting away again.
**QUESTIONING BY MR MOLLOY CONTINUED**: You also say kids were absconding from Lake Alice at times.
A. I was aware that sometimes that happened but not very often.
**Q.** Why do you think they were running away, what sort of reasons?
A. They had a -- from my memory they had a already -- a pre-existing history of absconding

from the other institutions from which they came, and unfortunately it sort of is a self-reinforcing thing, once you start doing it and it is reinforcing during the time that you've absconded, it's difficult to extinguish that behaviour.

**Q.** Did you ever explore that in group therapy or any other context?

A. No, because the groups were not structured that way.

**Q.** Was there an assumption that the kids, by absconding, were somehow behaving inappropriately?

A. That's an interesting question.

**Q.** Well, I'll ask it a different way. Was thought ever given to the possibility that kids were trying to get away from something quite legitimately?

A. Well, with the benefit of hindsight you and I can suppose that sometimes that would be the case.

**Q.** At the time it didn't occur -- I'm not directing all this at you, I'm just wondering.

A. Thank you.

**Q.** Among the staff, were those kinds of questions asked?

A. I don't think so. It's just that when the staff, and I'm only supposing, that they have a duty of care and that duty translates into containment of the people to Lake Alice, it's a bit like the Mental Health Act in a compulsory treatment of people, yes they can escape if they can, but they get brought back and your question, however, might still be as pertinent in that situation, are they trying to get away from things which are horrible and unpleasant and degrading and dehumanising.

**Q.** Well, if they had manifested as many of the criteria that are listed in the ACE tool, it might seem odd that they would be running back to it with vigour, so perhaps the question might have been asked, what are they running away from?

A. Well, maybe the other supplementary question is what are they running to?

**Q.** Well, either way, did you ask it?

A. No, because I was only there for learning about group therapy, I was not given any role in individually treating people and helping them to come to grips with what they've experienced like I would now. **[Interjection from the public - "bullshit"].**

**CHAIR:** Mr Soeterik, did you know that -- we've heard a lot of evidence from the survivors, that when those who did run away or tried to run away, when they were apprehended and brought back were punished by being put into seclusion, given ECT, Paraldehyde for their troubles. Did you know that -- you obviously heard that's the case now, did you know it at the time?

A. Not really, no.

**Q.** What does that mean "not really no"?

A. Well, I come there with a short timeframe in an afternoon, I have to talk to staff about the tests they've collected and collect those back, I talk with the staff about -- I participate with the staff in the group therapy, there might be some things about, discussion about the group therapy. Sometimes they would bring forth an issue, like for example with the boy who was smashed up the dental unit, and then they would ask me could you think of something better and I did. But other than that I would not really deal with the individuals.

**Q.** To you Mr Molloy.

**QUESTIONING BY MR MOLLOY CONTINUED:** You made some quite perceptive observations about the culture of the place, you know, when you got there. Presumably you were able to continue to observe, make observations about the culture of the place, how the children were. You mentioned some divisions among the staff and the way that they approached things. Some tended to be more child friendly. So given what we've learned subsequently about the manner in which Paraldehyde was used punitively, and it wasn't the only punitive tool, can you offer any reflection on why you remain so oblivious to it at the time?

A. Well, if I had a more conscious strategy on reflection, I might have been more confrontational like you suggested earlier on about all sorts of things. But my strategy on reflection really is to make little changes bit by bit in the direction away from seclusion, in the direction away from the use of punishment, in the direction of more treatment orientation, in the direction of more user friendliness for the adolescents who are actually in the process of growing and becoming and making it more possible for them to focus on those things which are positive about growth rather than proposing anything and everything in the process.

**Q.** Again, that suggests that you thought that there was something --

A. Of course I did.

**Q.** -- to change.

A. Of course I did and I still do.

**Q.** A punitive environment.

A. And I still do.

**Q.** But you weren't aware of the extent of the punitive tools used apparently.

A. Well, I knew their names, I knew what their results were and where possible and I could make a direct confrontation about it, an ultimatum as you put it earlier, I would make such

an ultimatum, because if it goes against the grain, if it goes against one's values, then one should be able to be accountable and stand up and say so. But it's also a matter of speed with which you create changes. I think had it been up to me, I would have closed the place down, altogether and start again somewhere else.

**Q.** Why was that?

A. Because it's difficult to make those kinds of cultural changes when they've been well ingrained over a long period of time.

**Q.** And it must have been stark, in stark contrast to the manner in which therapy or therapeutic, to the therapeutic environment at the child unit at Manawaroa.

A. It was hugely different.

**Q.** Tell us about some of the differences.

A. Well, first of all the children who came to Manawaroa were brought with their parents, the child did get the therapy, but so often in -- at the same time the parents did as well, they'd sort of get help and support and treatment for being parents of different, difficult children and do some family therapy and work together. I can't remember entirely, towards about 1974ish they built on an extra wing on to the children's unit at Manawaroa, they built in a video suite so people could begin to see the direct feedback about themselves and their behaviour and so on. We worked together in child psychotherapy, play therapies, all sorts of other options which were not available.

**Q.** Was there seclusion?

A. No.

**Q.** Was there Paraldehyde?

A. No.

**Q.** Was there faradic shock therapy?

A. People only came one hour at a time.

**Q.** Was there faradic shock therapy?

A. No.

**Q.** So a massive contrast in the delivery of child psychiatric services?

A. Absolutely.

**Q.** Just one last question I'm going to ask you. I think at paragraph 110 of your statement you mentioned that Dr Leeks had some support for his methods from other child psychiatrists. Can you recall who they were? Paragraph 110, the penultimate paragraph.

A. As I recall it I was already asked that question and my answer was no I don't --

**CHAIR:** The microphone, sorry, it's racing away.

A. Sorry, I was looking for 110.

**QUESTIONING BY MR MOLLOY CONTINUED:** You can't recall?

A. No, I know that there was, like I said from memory about four or five. I did deliver some papers.

**Q.** Was it either of the other psychiatrists at Manawaroa?

A. No, they were from elsewhere.

**Q.** And when you say they were in support of his methods, do you mean the use of group therapy or the use of Paraldehyde as punishment, or the use of faradic shock therapy, or some form of it?

A. I have no knowledge of that because I was only there to give a paper, and when I did and answered questions about it I left. But my purpose was for him to collect a greater collegial support for what he was doing, but at the same time behind that purpose was also another purpose, which is to make him more accountable and to see if he could present what he was doing to them when it did not have general psychiatric support and opinion that it was medically sound and correct that they would also as a group say so.

**Q.** Do you recall that at either of those fora in 75 and 77 where other psychiatrists came, do you recall Dr Leeks presenting about his use of Aversive Therapy or something along those lines?

A. No, but all I have a memory of is that I think he organised for it to happen at Lake Alice. So he must have -- I made that assumption that he must have invited them there and --

**Q.** Thank you Mr Soeterik, I'm going to hand over to Ms Joychild.

**QUESTIONING BY MS JOYCHILD:** Good afternoon Mr Soeterik.

A. Good afternoon.

**Q.** I'm representing the survivors of Lake Alice, so I've just got a few questions. I appreciate we're out of time so I'll try and be quick. Mr Soeterik, survivor after survivor after survivor identifies you as the person who ran the group therapy sessions. Does that surprise you in light of --

A. It does.

**Q.** Right.

A. I certainly am a person who likes to follow through with commitment, so when I say I'll come, I come, and I think continuity is important. So if I'm a person who provides the most continuity it's quite easy to imagine that therefore it's all done in my name, organised by me, etc. But that's --

**Q.** You were seen as Dr Leeks' right-hand man.

A. Apparently, yes.

**Q.** Now, survivor after survivor after survivor who were in the unit at the time you were have said everyone has said that if you didn't speak up in group therapy you either got Paraldehyde or ECT. Did you know that?

A. No, that I did not know, but I might -- if we're just looking at the ECT part, as I said previously when I was talking about ECT, ECT to my knowledge is given in a dose, so let's say the psychiatrist thinks it's important to give ECT for this particular condition, it's not one ECT but usually four or five or six or eight, sometimes if it's really intractable maybe even more. So if when I look at what do people who get ECT make of ECT on a regular basis, when the only other regular thing is to get the group therapy and they didn't talk, it's quite possible that they might think that it's that way because they didn't talk rather than for other reasons.

**Q.** Okay, well I'll just take you through the example of Ms LL who gave her evidence yesterday. She said that once she was sarcastic with you in a group -- perceived to be sarcastic in group therapy and you ordered that she be given Paraldehyde.

A. How did she know that I had the power, the role, the way, the means to do that? I thoroughly reject that.

**Q.** She says another time where she leapt up in the group therapy session because her father was -- had arrived in a truck and she was calling out to him to come and get her, she disrupted group therapy and she got Paraldehyde for it.

A. I know nothing about that. But I do not agree that it was me who organised for her to get the Paraldehyde.

**Q.** You didn't meet with Dr Leeks and talk about the results of group therapy?

A. No.

**Q.** Mr Richards, who gave evidence last week, gave a situation of a damned if you do and damned if you don't. He did speak up in group therapy because he was worried about ending up getting punishment. So he disclosed that he'd been sexually abused by a teacher and lo and behold he's sexually harassed in the unit from then on by some of the other boys. Was that a very safe group therapy environment do you think?

A. When you look at that example, clearly not, but it's a bit like a group with drug addicts and alcoholics and so on, everyone should go into group knowing that what is said in the group stays in the group, but every personal disclosure we make to somebody else is self-disclosure, always runs that risk that somebody will misuse it. But I can't account for why they got Paraldehyde or ECT because I was not treating anybody individually.

**Q.** Okay, well, we'll just move on from there. You've already made that statement. I'd like to put up on the exhibit, it's Paul Zentveld who's giving evidence tomorrow, it's 341039. It's a letter that you wrote to ACC in relation to Mr Zentveld. It should come up on your screen. There it is. Now it's the bit were you working from the Victoria Medical Centre.

A. Yes, I was.

**Q.** So you'll see there at the top it's to Warren Maguire, clinic advisor, treatment injury ACC.

A. Yeah.

**Q.** And it's about Paul Andrew Zentveld.

A. Yes.

**Q.** If you go down to the last paragraph in that sentence you've been asked about Mr Zentveld's claim, if we highlight that last sentence, "As far as I recollect, Dr Leeks from time to time administered unmodified ECT treatment to adolescents and sometimes to adult patients at Palmerston North. Nursing staff at Lake Alice were also at times authorised to use Paraldehyde injections for poorly controlled adolescents and adult patients." And, then could we go to the next page?

**CHAIR:** Just be a wee bit slower, it's the end of the day.

**Q.** "I have no direct information about patient consent, but I understood guardians or parents were involved in the decisions to treat on an inpatient basis", and you say "beyond this general recall of Lake Alice practices I cannot add much more since I was not directly involved in either Mr Zentveld's care or the adolescents in general."

So that's consistent with what you're saying today, that really you had no -- not much roll-out there at all.

A. Not with the individuals.

**Q.** Not the individuals. Well, I'd like to put up now on the screen Exhibit 341020. This is a letter, and it's to a Dr McKay, that's irrelevant, and what is relevant is who's a signed it and it's M L Benson, medical officer for the medical superintendent. And you'll see in the middle paragraph he's talking about a patient giving details there obviously Dr McKay wanted information for a patient. Now at the bottom it says, you know, where we are here, the third paragraph, "Further details of his treatment will probably be obtainable from either Dr Leeks or Mr Soeterik, the clinical psychologist in Villa 7". So you were perceived by the Lake Alice management as being the clinical psychologist in Villa 7?

A. Clearly.

**Q.** So all the patients' perceptions of you as a man with a lot of influence are completely accurate, aren't they?

A. In what way?

**Q.** You are the clinical psychologist for the villa.

A. No, I was the clinical psychologist visiting the villa.

**Q.** Well, "visiting" or "in", the word here is "in villa 7".

A. Yeah, but it makes a big difference in terms of meaning.

**Q.** Well, I put it to you, Mr Soeterik, that you are grossly underestimating the impact and the influence that you had in the Lake Alice Child and Adolescent Unit.

A. **[Nods]**.

**Q.** What's your statement to that?

A. Well, looking at the evidence that's being presented that would seem to point in that direction. I did not set out to be grossly influential in anything, I just was there to learn, but I speak my mind when I need to.

**Q.** Well, you've given one explanation as to why the survivors might have thought they were receiving ECT after group therapy, you say because it was -- they might have been having a series of it. But the evidence is that unmodified ECT, which is what the vast majority of the complaints are about, was never done in a group, it was a one-off type of ECT. So that explanation doesn't really fit. Neither does it explain why everyone thinks they got Paraldehyde if they didn't speak up in group therapy.

A. Well, that last bit is news to me, but the ECT bit, like I was there say, over a period of two days a week, do the maths, we're talking about 80 possible group therapies and some people say "Well every time I didn't talk", which was most of the time, you would have had 80, or say give or take 10, less, say 70 unmodified ECTs per person. I don't think that's what happened. **[Interjection from the public "I had 94"]**

**Q.** Just moving on, can we put up on the screen 0341006, maybe it's 8. Again, this is in relation to Paul Zentveld. And we'll know in the previous letter you said you had nothing to do with him, in the letter to ACC. But if we look at page 2 of this document, you've signed it and then there's a summary, which makes it clear you've done some analysis of Paul while he's been in either Manawaroa or Lake Alice.

"Paul has a long-standing adaptation reaction and a neurotic disorder characterised by a conversion reaction and enuresis. Paul's intellectual level is within normal range. The environment and etiological factors seem to be—

**CHAIR:** Slow down please.

**Q.** The environment and etiological factors seem to be something to do with being caused by a foster father as a model for behaviours and a disturbed and deprived mother, lack of

consistent care."

To be able to write that you obviously had to know Paul quite well, didn't you?

A. Not necessarily at all. You'll recall I said today that we started to deliver to the staff a series of MMPI adolescent forms, much of that would be derived from the test. So while it may look like I know an awful lot over a long period of time individually, may actually be derived from what you could extract from the test.

**Q.** Okay. You were a good friend of Dr Leeks, weren't you?

A. I was friendly with him and he gave me a very positive start in my career.

**Q.** How do you feel now that we see --

A. After all I've heard I'm deeply saddened, because no-one should actually have to experience those sorts of things. So I'm saddened that he actually allowed those things to happen, if he was aware of it, and B, perpetrated some of those things, he must have known what he was perpetrating, and I think it's extremely distressing.

**Q.** Did you feel a bit let down by him?

A. Yes, I am.

**Q.** No further questions.

**CHAIR:** Thank you Ms Joychild. I'll just ask my colleagues if we have any questions.

**COMMISSIONER ALOFIVAE:** Mr Soeterik, I'd just like some clarification if I can. Going back, you were there to undertake a thesis for your masters?

A. No, no, I was at Manawaroa Child and Family Unit, children's unit to obtain access to hyperactive children as they came on-stream consecutively. So that's what I did my thesis on originally. The Lake Alice thing was separate altogether. Different learning programme.

**Q.** Okay, but you needed -- I guess what I'm interested in in being able to understand and to be able to support your thesis, did you have access to the nursing notes to be able to form your views?

A. For my thesis.

**Q.** Yeah.

A. So we're talking about two different institutions, Manawaroa, it's in Palmerston North, yes.

**Q.** Yes, that's right.

A. So people, parents and the children that I saw there were from -- identified by Dr Leeks as probably being what they call now ADHD.

**Q.** Yeah.

A. So the notes would not be from any nurses because they are not seen in an inpatient setting,

they are an outpatient. So they'd be either Dr Leeks' note but more importantly my own notes because I went and sampled the children at their homes, sometimes I'd arrive between 6 and 8, sometimes at 4 and 5 so we get time samples seeing how they behaved in different parts of the day. So most of those notes would not ever be in the nursing notes.

**Q.** But when you were down at the Child and Adolescent Unit and you were there as an observer, were you able to have access to the nursing notes?

A. I think if I asked nicely I would have, but that's not something that I actually wanted to do.

**Q.** I'm just trying to ascertain, so you were there to observe those children as well?

A. No, I was just trying to learn group therapy.

**Q.** And in order to understand group therapy, did it occur to you that maybe the nursing notes might be of some interest to understand the young people better, or to get a fuller picture at least?

A. Well, if you think about group therapy as a conversation, the conversation happens within the group, otherwise you go into a group with preconceived notions about -- so then it's not what you see is what you get, it's what you understand, it's what you'll end up seeing. It's kind of like if you're trained to see a bit in a certain way because they've been judged this way or diagnosed this way or described this way and that way, then you begin to want to see that from the person in front of you. In many ways a lot of therapy is allowing the person to speak for themselves.

**Q.** So you only ever see them in a group but not individually as such to be able to understand them and to be able to kind of really come up with the differences in understanding the background?

A. Yeah, so for example, the little boy in the dental unit, I did not see any clinical notes, I did not see any nursing notes, I did not see his background history, none of that was relevant. Trying to stop him to wreck the place, trying to get him to become comfortable about being seen. We all agreed with, including him, that we do this only once or off four quadrants of his mouth with the target for when he finally saw the dentist, and then we worked on that programme and that only, and the dentist next day successfully treated him, he stopped being panicky.

**Q.** And I noticed you made a couple of references, just a point of clarity please around family meetings. So you said that part of your contribution was at your paragraph 30, your main contribution to the adolescent unit was to help carry out psychological testing and sit in on family meetings. Some individual and group therapy as well as to contribute to some staff training. And then I think it's at paragraph 42 you say that there was an increase happening

in meetings between families and staff but you didn't attend them. Can you just -- so did you attend any family meetings or not?

A. I did once, when they first were instituted, but my point, I made it clumsily, I beg your pardon, it's another one of those suggestions I made about the school and other sorts of things it would be better to begin to involve the parents where possible with the treatment and the treatment goals and aims so that they actually are supportive of the child who's in care, and also that they go back to a more supportive environment. So tried to get the staff to become interested in going there and doing that. But if I followed up each one of my suggestions myself I wouldn't have the time available.

**Q.** Thank you. I've got a few more but I'll pass it on, thank you.

**CHAIR:** Commissioner Gibson.

**COMMISSIONER GIBSON:** Thanks Mr Soeterik. You talked about Dr Leeks going on some trips to a range of other homes, Hokio, Kohitere, Kimberley, I think some places like New Plymouth, Hawke's Bay. Were they seeing young people in clinic or what was the purpose of that, to possible admissions?

A. Yeah, literally was my understanding that he would be consulted about the various people in these State care situations, and he would then make an assessment and then institute where necessary admissions.

**Q.** And I'm aware of a lot of those places but you talk about New Plymouth, Hawke's Bay as well?

A. Yeah.

**Q.** Were those in smaller homes or were they in GP practices?

A. I don't know all the details, I just listed some of the ones I do remember, likely Epuni Boys in Lower Hutt, or Epuni, yeah, Kohitere and Hokio Beach. Kohitere, for example, I did go with him there once when we met a gentleman who's now Professor Gary Hermansson who was the counsellor there at the time, and he and Dr Leeks discussed some admissions which I didn't sit in on because it's not relevant for me to be in there.

**Q.** I was just wondering about the places beyond those boys' homes?

A. Margaret Street Girls' Home in Palmerston North, I think he went to New Plymouth but I don't know exactly where, I also was aware he went to Hastings I think but I'm not sure where in Hastings.

**Q.** Another question, you spent time with Dr Durie as well. Did he ever visit Lake Alice, was there any opportunity for any Māori cultural input into the place from him?

A. Well, I'm sure, knowing Dr Durie as I do, he would have made the opportunity if that was

something he wanted to do, but he was actually pretty busy, but I had the privilege and pleasure of taking him to and from work for a long time, and I learned a lot from him in the process.

**Q.** Did he ever speak to you, sort of share his thoughts about in general what was going on at Lake Alice but also specifically about what was happening of overrepresentation of Māori in these places and how you and others could have or should have responded?

A. Well, no, he did not, he was busy at one stage to create his model of Te Whare Wha and then I believe he became a Commissioner for a while and then he became -- I thought his best move that he did for his people was to actually become the Professor of Māori Studies at Massey University, because I thought he could -- he actually regretted, I think from memory, that because he missed psychiatry, actually he really liked being a psychiatrist, but I said to him you'll do more for your people this way than you could do in psychiatry.

**Q.** You're trying to push for a more collegial means of accountability and --

A. Yeah.

**Q.** -- cross-pollination; was this thought of at all within the people involved with Lake Alice by Dr Leeks yourself and others?

A. Not exactly that I'm aware of, no, but I just know my own motive, I didn't think, like Don Quixote, I should be tilting at windmills all the time. I knew when somebody pushes my boundaries and edges in terms of values and systems and knowledge base, I also thought that if you make changes one step at a time you still generate changes, and that's basically what I thought I could do as a student from -- is what I thought I could contribute. I always believe in trying to make a contribution.

**Q.** Thanks Mr Soeterik, that's all my questions.

**CHAIR:** And I don't want to labour, but just one area, Mr Soeterik from me. Coming back to the meetings that were held with the other psychiatrists, you said in describing that, that one of the things that you thought might be of benefit was that Dr Leeks would be learning about accountability.

A. That's right.

**Q.** Yes, in what respect did you think he needed to know about accountability?

A. Well, there are two general sources of thinking about that for me. If we look at --

**Q.** I'm going to cut to the chase.

A. All right.

**Q.** Do you think that he was accountable and if so -- in his practice at the adolescent unit?

A. I don't really think so, no, looking back on it.

**Q.** So he was in effect a lone wolf pursuing his own theories and methods of treating children and adolescents?

A. Well, as I understand the history of it, the Health Department gave him a job to do and he was accountable to them rather than the normal route of employment via a Hospital Board where he would be more accountable for his actions. And I think he was not very much held to account in the beginning, so I thought it came as a bit of a surprise to him, I said "Well, I won't come if that's what you do", for example, about the punishment, of the ECT.

**Q.** All right thank you, you've answered my question. I think unless there's anything arising we should call a halt. Thank you very much. Mr Soeterik, we appreciate the effort you've gone to to collate your evidence and come here and sit there for all this afternoon, we wish to thank you for making your contribution to the Royal Commission's work.

A. Thank you.

**Q.** Thank you. We'll close.

**Hearing closes with waiata and karakia mutunga by Ngāti Whātua Ōrākei**

**Hearing adjourned at 5.36 pm to Thursday, 24 June 2021 at 10 am**