Witness Name: SHEREE BRIGGS

Statement No.: WITN0681

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ROYAL COMMISSION OF INQUIRY INTO ABUSE IN CARE

WITNESS STATEMENT OF SHEREE BRIGGS

I, Sheree Briggs, will say as follows:

1. Introduction

1.1. My name is Sheree Briggs. I am a psychologist and certified behavioural analyst based in Rotorua.

1.2. Earlier in my career, I spent four years working as a psychopaedic training officer. The term "psychopaedic" was specific to New Zealand, and referred to the care of people with intellectual disability.

1.3. My work was primarily based at Māngere Hospital and St John's Home in Auckland.

1.4. I retrained as a psychologist in the 1990s, after the process of deinstitutionalisation led to the closure of psychopaedic hospitals in New Zealand.

Psychopaedic Training Officer

1.5. I left high school in the mid-1970s without completing my School Certificate, to enter a role at IHC as a carer in a residential care facility. This was my introduction to working with people with disabilities.

1.6. After working at IHC for a few years, I went back to high school to complete my School Certificate and obtain University Entrance. This allowed me to enroll to train as a psychopaedic training officer. I then began my psychopaedic training in 1979 at the age of 18.

1.7. It took me about three and a half years to get my psychopaedic training officer qualification. Most of the teaching was learnt on the job in the training centre at Māngere Hospital. As part of the programme, I spent six months at the national training centre based in Kimberley Hospital, Levin.

1.8. The training had a specific focus on behavioural modification theory, where I was trained in methodology to reinforce positive behaviour, discourage negative behaviour or encourage alternative behaviour.

1.9. A lot of my training was focused specifically on working with children, which became a particular focus throughout my career.

Māngere Hospital and St John's Home

2. Abuse

Introduction

2.1. When I first started working at Māngere, there were about 660 residents living in 11 residential units. There was also another house down the road called Baker House which catered to young children with physical disabilities.

2.2. There was a training centre onsite at Māngere, which is where I primarily worked. I would go to the residential wards when my role required, however most of the wards were locked and I wasn't able to enter.

2.3. The grounds at Māngere were sparse, as the hospital was spread across 10 acres of land. There was also a playground area around the back of the hospital. However, most of the residents were not allowed to roam the grounds freely.

2.4. While working at Māngere, I also spent part of my time working at St John's Home. St John's was a residential facility and industrial workshop for people with intellectual disabilities at a site near Māngere in Papatoetoe.

Training Centre

2.5. The training centre was attended by about 80 residents each day. There were also a few people with intellectual disabilities who lived in the community who came to the training centre.

Arrival in institution

2.6. Prior to arrival, parents and families were actively discouraged from maintaining a relationship with their child. They were told that ongoing contact was bad for both the child and their family. Home leave was an option for some residents, but it had to be preapproved, and requests were frequently dismissed by staff. Whānau visits were actively discouraged, and there was also no designated space for whānau or guests at Māngere. This made day visits very difficult.

2.7. As I spent most of my time working in the training centre at Māngere, I didn't have much experience with the new arrivals. However, some new arrivals were taken straight to the training centre on admission, where I would be one of the first staff members to meet them. This was more common for people arriving for respite care at Māngere, rather than permanent residents.

Day-to-day life in care

2.8. There were about 12 residential units at Māngere, with each unit catering to a group of residents with similar needs and ages. Each ward had a fenced outdoor area, which meant that walks were one thing to keep residents stimulated (for those that had the mobility to do so). All the units were reasonably standalone.

2.9. In terms of interactions between staff and residents, I feel that the training officers had more compassion towards the residents than other staff. Specifically, many of the nurses and nurse aids took more of a domineering approach when interacting with residents. I remember wondering at times if the need to be in control of people was more of a driving force than the need to actually help people. I think this is because they hadn't had adequate training in working with people with intellectual disabilities.

2.10. The residents who attended the training centre often had things to keep them busy, and they had individualised behaviour plans to advance their skills and improve behaviours. However, the rest of the residents did not have any individual goals and spent their days in the wards. It was often a day of nothingness in a barren room, particularly for the residents with limited mobility.

Aversion therapy

2.11. Aversive or punishing consequences were a key component of behavioural modification practices at Māngere. This involved managing difficult behaviour by using an unpleasant stimulus as a consequence, to discourage that behaviour. At Māngere, these aversive practices included:

a. electric shocks (primarily through belts, but also helmets);

b. ammonia capsules;

c. medication (commonly paraldehyde, sedating or anti-psychotic drugs);

d. time out boxes/ seclusion;

e. cold showers/ fire hoses;

f. spraying water to the face; and

g. removing attention.

Seclusion

2.12. Seclusion was one of the more common strategies to manage residents' behaviour at Māngere. The instances of seclusion that I witnessed were primarily in the time out boxes in the training centre, though seclusion was also used in the residential wards.

2.13. Psychologists had policies and plans for how the time out boxes were to be used, but this was usually based on how calm (or not calm) the child was, rather than a set amount of time. If the child didn't calm down, they could be left in there for up to an hour before being let out.

2.14. There was no lid on the time out boxes, but the boxes were so small that the kids could barely move while in time out. No one ever went into time out willingly. As there were many kids for the staff to look after, I imagine that some kids would have been left in there for longer than intended at times.

Physical abuse

2.15. I never saw staff punch or physically assault residents, but I did witness a lot physical aggression and assaults between residents. This aggression often wasn't dealt with properly by staff, though it was less of a problem in the training centre than in the wards.

2.16. There was also the issue of residents biting staff and other residents, though this was often resolved by residents having their teeth pulled out by the onsite dentist. These practices of teeth pulling were very normalised and openly talked about between staff.

2.17. On one occasion, one resident kicked another resident in the head, which rendered him blind. I believe that staff could have intervened, but they chose not to. One of the residents involved usually listened to instructions from staff, so I believe that this incident could have been prevented if staff had tried to intervene.

Sexual abuse

2.18. There were sexual relations between residents at Māngere, but this wasn't freely discussed between staff. However, I did not witness any explicit sexual assault by staff towards residents at Māngere.

2.19. There was a lot of sexual behaviour between staff and male residents at St John's. The behaviour wasn't necessarily physical, but there were a lot of sexual jokes, encouraging the residents to do sexual things, and taunting them about sex.

2.20. There were two residents in particular that had tendencies towards same sex interactions. Certain staff members would make fun of them and make nasty comments about their sexual interactions. Looking back, I suppose there was a homophobic element to these nasty comments, but at the time ableism felt like the main reason for their comments (i.e. that disabled people should not be having sex).

2.21. I can recall a charge nurse who appeared to target men and women at St John's. I have reason to believe he sexually abused them, but I don't have proof of this. He also used to taunt and mimic the residents. For example, there was one resident who had an obsession with trucks, and this charge nurse would wind him up by telling him there was a truck coming. He was very cruel to the residents and took pleasure from seeing them get agitated and upset.

2.22. I also remember that menstruation products were given to women at St John's, and some female residents were given Depo Provera as contraception.

Psychological abuse

2.23. There were some nasty punishment tactics that staff used when residents soiled themselves, such as using fire hoses or cold showers. The residents would cry and yell. This was more commonly used in wards that housed residents with really challenging behaviour, as those wards often attracted a certain type of staff member. These staff had fewer inhibitions when dishing out punishments, compared to the staff on other wards.

Neglect

2.24. There was very little privacy for residents at Māngere. This differed between wards, but in general privacy was minimal. There weren't any doors on the toilets, even in the training centre. Residents couldn't shower by themselves, even if they had the ability to do so.

2.25. At times residents could go hours without being changed if they soiled or wet themselves. I also recall that residents frequently had to wear incontinence pads that didn't fit them properly.

2.26. Residents at Māngere basically had no personal effects, not even personal clothing. In the adult wards, the residents just wore grey shorts and a coloured shirt that indicated which ward they lived in. There was minimal access to toys or music. There was a real lack of stimulation for residents who spent their days at the wards.

2.27. As a psychopaedic training officer, I wasn't really allowed to visit the wards. However, one day I ended up at a ward after taking a child back there from the training centre. When I walked in I saw there were toys stuck to the walls, out of reach of the kids. I retrieved these toys and gave them to the kids to play with. Supposedly they had been placed out of the children's reach so that they didn't ruin them. When a senior charge nurse found out about this, I was reported, and a complaint ended up on my record. That didn't bother me, the whole process just made me more defiant. I wasn't allowed to enter that ward after the complaint.

2.28. There was a significant neglect of residents' culture at Māngere. There were no cultural events, no support of residents' cultural identity and no recognition of culture at all. There was also no celebration of birthdays in the hospital, and a general lack of promoting personal identity.

2.29. The residents at Māngere did not receive adequate medical care. Medical issues like ulcers and bedsores often went undetected. One example is a resident who died from pica

syndrome, which meant she couldn't stop eating non-digestible things. It turned out the reason she had pica syndrome was because of an ulcer in her stomach, which hadn't been detected by a medical professional. If this had been detected earlier, then she wouldn't have developed the condition.

2.30. There was also no informed consent from parents when it came to residents' medical issues. This lack of communication was compounded by a failure to meet residents' basic needs. I can recall one example of this, where the staff's failure to properly treat a resident's contractures ultimately led to the amputation of his legs.

2.31. Despite the widespread neglect at Māngere, I remember that some wards were better than others. For example, in unit 11, there was good emotional support for residents and a better culture throughout the ward. This shift in culture was because of the leadership of the charge nurse that led this ward.

2.32. In terms of Deaf culture, there were a few Deaf residents at both Māngere and St John's. Some of them could sign fluently, but not all of them, so they would come up with their own unique signs to communicate. There were some staff who could sign with these residents and were able to teach them to sign. However, it was particularly challenging for Deaf residents to learn sign language if they had a significant intellectual disability.

3. Complaints

3.1. I am not sure if or how residents were able to complain about their care at Māngere. It would have been near impossible for non-verbal residents to make a complaint. They were not able to go the Police, and they were definitely not made aware of their legal rights and human rights.

3.2. In terms of staff making complaints, I think that staff were apprehensive to complain about other staff. It was very hard to reprimand other staff without fear of being forced out. I can't recall any disciplinary action being taken against staff during my time at Māngere in regard to maltreatment of the residents.

4. Looking forward

4.1. There is a lot we could be doing to improve care for disabled people in New Zealand today. Despite having progressed a lot in certain areas, there is still so much more change that could be done to improve the lives of disabled people.

4.2. It is important to acknowledge the financial barriers and funding limitations from the outset. There are some great ideas out there for improving disability care services, but these can't be brought to life without a significant shift in funding models. I think we should look to countries overseas, particularly Scandinavian countries, on what this might look like.

4.3. Care and treatment of disabled children should be early and intensive. It must be evidence-based. Many special schools today still operate on a similar model to the unstimulating environment at Māngere. Special schools shouldn't just be a baby-sitting service; there is real opportunity to help disabled children prosper and thrive. It is also

important to consider how environmental factors contribute to a child's disability, rather than putting blame on the individual.

4.4. In terms of care for disabled adults, I acknowledge the contention around whether care homes or in-home care are the best environment. I personally believe that purpose-built homes make sense where possible, especially where individuals have complex medical needs alongside their disability. However, it always depends on an individual's specific needs, so it is not right to take a one size fits all approach.

4.5. I also strongly believe that staff in the disability sector need better training, especially when they are working with clients who have complex needs. Some staff these days don't even have basic first aid training. It is also important that a carer's pay reflects their worth.

Statement of Truth

This statement is true to the best of my knowledge and belief and was made by me knowing that it may be used as evidence by the Royal Commission of Inquiry into Abuse in Care.

Signed GRO-C

Dated: 24 Jan 2022