

**ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
DISABILITY, DEAF AND MENTAL HEALTH INSTITUTION HEARING**

Under The Inquiries Act 2013

In the matter of The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions

Royal Commission: Judge Coral Shaw (Chair)
Paul Gibson
Julia Steenson

Counsel: Mr Simon Mount QC, Ms Kerryn Beaton QC, Ms Ruth Thomas, Ms Lucy Leadbetter, Mr Michael Thomas and Ms Kathy Basire for the Royal Commission
Mr Gregor Allan, Ms Sandra Moore and Mr Vaughan Dodd for the Crown

Venue: Level 2
Abuse in Care Royal Commission of Inquiry
414 Khyber Pass Road
AUCKLAND

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TRANSCRIPT OF PROCEEDINGS

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26

Adjournment from 9.52 am to 9.58 am

27

CHAIR: Yes, Ms Basire.

28

MS BASIRE: Thank you, Madam Chair. Our next witness is Olive Webb, but before we start Dr

29

Webb's evidence there is a very short clip to be played on Sunnyside Hospital if that could

30

be played now.

31

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

32

[Video played]

33

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

34

A. Absolutely.

DR OLIVE JEAN WEBB (Affirmed)

QUESTIONING BY MS BASIRE: Thank you, Madam Chair.

Please state your full name.

A. Olive Jean Webb.

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

A. I am.

Q. What area do you specialise in?

A. Intellectual disability and/or autism.

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

A. That's right.

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

A. That's right.

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

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

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

A. That's true.

Q. And at 75 you're still working?

A. I am.

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

A. Yes, I am.

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

A. That's right.

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

A. That's right.

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

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

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

4 **Q.** What impact did that have on you?

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

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

9 **A.** Yes.

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

12 **A.** That's right.

13 **Q.** And can you briefly describe that for us?

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

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

22 **A.** That's right.

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

26 **A.** Well, yes.

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

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

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

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

8 A. That would be right, yes.

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

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

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

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

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

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

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

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

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

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

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

- 1 **Q.** How was it that you ended up working in the back wards?
- 2 **A.** Well, I'd had my home grounding of course, and I had known, through the family, people
3 who had intellectual learning disabilities, and I had an in terest in the relationship between
4 the environments in which people lived and how they behaved, and just immediately next
5 to the psychology department was a very long-term back ward and I got permission to go
6 and spend time there, which of itself generated a lot of anxiety because most psychologists
7 didn't go there.
- 8 **Q.** So it was your own motivation that enabled you to start working in these areas and
9 effectively in 1974 you were appointed as a psychologist for the, what was called the
10 Mentally Handicapped Area?
- 11 **A.** I was -- yes, I was a registered psychologist at that time and I was made clinician in charge,
12 a noble-sounding term that put me as the manager of that service area.
- 13 **Q.** And this wouldn't have happened unless you'd shown an interest in the area?
- 14 **A.** No.
- 15 **Q.** I want to take you to your description of North House which was one of those wards. I
16 understand there were about 70 men in that ward, and those men were predominantly
17 Pākehā?
- 18 **A.** Mmm-hmm.
- 19 **Q.** And aged between about 50 and 70?
- 20 **A.** Yes, I'd say, yes.
- 21 **Q.** We've just seen a shot of the dormitory, can you describe what North House looked like in
22 terms of the sleeping arrangements?
- 23 **A.** North House was quite different to what you saw there. In North House, there were about
24 70 men living there, there were two or three dormitories, and I remember well my first tour
25 of the ward, I had to move sideways to get in between the beds, they were sufficiently close
26 together, and at the end of each dormitory ther e was a lobby that had the clothes store in it.
27 People didn't have their own clothes and so they fished around and found something that
28 was usually too big or too small.
- 29 The first day that I spent there I was there early in the morning and these men
30 were -- got up from their beds, shuffled into that lobby, stripped naked, they were then
31 marched, or sort of herded really, through the main villa and through the end of the day
32 room, into this large bathroom that had multiple shower heads, they were showered
33 en masse by nursing staff who were wearing rubbers and gumboots. They were then taken
34 out and dried and then herded back to the lobby where the clothes were.

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

- 1 **Q.** What sort of behaviours would trigger a nurse thinking that somebody had behaved badly?
- 2 **A.** Oh, being non-compliant, getting cross with somebody, acting out in those sorts of ways,
3 yes. It didn't take much.
- 4 **Q.** Was there any attempt to understand why a person was behaving that way?
- 5 **A.** I think we were a bit more solutions driven than that at the time, that if somebody behaved
6 that way then that's what happened rather than "let's find out what is troubling this person",
7 yes.
- 8 **Q.** You've said in your statement that restraint and seclusion were often used. What sort of
9 restraints did you see?
- 10 **A.** Restraint was common, which could have occurred if somebody was being non-compliant
11 and challenging orders, as it were, or if somebody was acutely unwell and therefore
12 behaviourally out of control, it would be common for them to be restrained by two or more,
13 and sometimes a lot more people, and then secluded.
- 14 **Q.** And what did the seclusion facility look like?
- 15 **A.** The seclusion room was a bare room with a shutter, so a reinforcing over a window, a
16 mattress on the floor, and a potty.
- 17 **Q.** How long would people be kept in these rooms for?
- 18 **A.** It varied. There was a belief that seclusion was somehow good for people who were
19 disturbed because it reduced their level of stimulation, and so if people were unwell or still
20 angry and fighting the system, this would of itself extend the period of seclusion. So there
21 was not the control then, 1970s, there was not the control on the hours and days of
22 seclusion that there is now.
- 23 **Q.** Now you also mentioned to me that control was achieved effectively through intimidation.
24 Did the hospital employ members of staff who were physically imposing?
- 25 **A.** Absolutely. And it was common practice that if somebody was felt to require seclusion, to
26 ring up neighbouring wards so that you'd have half a dozen or eight burly men appear on
27 the scene and a person would be intimidated into seclusion in that way.
- 28 **Q.** Now I want to talk to you about the power imbalances and patient neglect. You've told us
29 in your statement that adult patients always had to knock at the door of the staff room?
- 30 **A.** That's right.
- 31 **Q.** So the staff were at the top of the hierarchy?
- 32 **A.** Yes.
- 33 **Q.** Patients were not meant to interrupt?
- 34 **A.** That's right.

- 1 **Q.** Nurses would say, "Don't talk to me now --
- 2 **A.** That's right.
- 3 **Q.** -- I'm busy." And it was because the nursing staff ran the show?
- 4 **A.** That's right.
- 5 **Q.** You've said in your statement, you've given us a couple of examples of neglect, specific
- 6 examples. Of course, you've told us already that these men had no stimulation, they just
- 7 stayed in the day rooms. You've talked about one guy who stood against the wall?
- 8 **A.** Yes.
- 9 **Q.** What was the physical result for him of always standing up beside a wall?
- 10 **A.** It sounds really bizarre. We discovered when we wanted to take people swimming that his
- 11 standing by the wall had meant that his scrotum descended just about to his knees, and so
- 12 we had to get special clothing for him so that we could take him swimming and get him
- 13 moving, yes.
- 14 **Q.** And I'll move on to, in a bit, the rehabilitation programmes that you implemented, but
- 15 I assume when you first started in North House, nobody was taking these men swimming?
- 16 **A.** No, no.
- 17 **Q.** Another example you've told us about is a man in a long bed-chair and he was always in a
- 18 bed-chair, never up and standing?
- 19 **A.** That's right.
- 20 **Q.** Can you tell us how it was you and a physio discovered why he was in that chair?
- 21 **A.** It was quite simple, a physio who I -- who worked with me in the area said, "Why is this
- 22 man in a bed-chair?" And we went through his notes and discovered that about 10 years
- 23 before he had broken a hip and there was no reason for why he should be in that bed-chair.
- 24 And -- so she went to work and it took quite a long time, but we actually got him up and
- 25 walking again. If you're horizontal for many years, it has all sorts of implications for your
- 26 vestibular system, but she got over that and he became able to walk again.
- 27 **Q.** So this man for 10 years had been in a bed-chair because nobody had bothered to give him
- 28 rehabilitation to get him walking again?
- 29 **A.** That's right.
- 30 **Q.** In your statement you've told us that you wanted to be clear that you never saw many
- 31 incidents of outright abuse, but you felt it was the system that was abusive?
- 32 **A.** Yes, I mean, like everyone else, I'd been reading some of the snippets of reports that have
- 33 been made here, and hand on heart I did not -- have not seen an individual staff person
- 34 being cruel. But the systems in which everybody lived and worked were terribly cruel,

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

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

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

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

13 **A.** Mmm, yes.

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

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

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

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

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

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

33 **A.** Yes.

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

- 1 A. It was very simple. He taught people with severe learning disabilities complex tasks
2 without ever telling them "No, you're wrong." He just simply said to them, "Try another
3 way." And people tried another way and for many years he had people assembling 22-task
4 bicycle brake assembly units commercially by simply following a jig board and performing
5 the task and getting paid properly for it.
- 6 Q. And because his view was if you try another way, just let's see what happens?
- 7 A. Mmm.
- 8 Q. So you decided, when you were made head clinician, as you say, a very important sounding
9 title, head clinician of the Mentally Handicapped Area, as it was termed on that day, that
10 you would try another way. Did you have support from your bosses at the time?
- 11 A. From my psychology bosses, yes. But I was regarded sceptically by staff within the
12 Mentally Handicapped Area, and I taught somebody quite quickly, in a couple of
13 afternoons, to do an equally complex task, and I was told, "Well, of course they can do that,
14 he can do a lot more than he does now." And this knowledge didn't seem to spur anybody
15 on to put more into this guy's life, you know.
- 16 Q. Right. So what you're saying is that you taught one patient something and the staff go, "Oh
17 yeah, we know he's capable of this, he used to be capable of a lot more", but they didn't see
18 that as neglect, that they'd allowed it to become that he wasn't doing anything?
- 19 A. No, no.
- 20 Q. I understand there was quite opposition to you introducing new measures, and there were in
21 fact complaints to doctors and nurses, governing bodies?
- 22 A. It wasn't so much complaints about me, but because my position was the first time that a
23 non-medic had been made a service manager and so the nurses went off to the nurses union
24 to seek reassurance that this was ethically okay and, similarly, the medical officer who
25 worked in the Mentally Handicapped Area went off to the Medical Council to make sure
26 that it was ethically okay for him to be directed by a non-medic.
- 27 Q. It's somewhat ironic given what was happening to these people?
- 28 A. Mmm.
- 29 Q. We're not going to be able to have time to talk about all of the things that you did in terms
30 of rehabilitation, but I just want to take you to some of the first examples that you gave us.
31 I understand that you chose a small group of people because you knew that you had to
32 show success to get support?
- 33 A. That's right.
- 34 Q. Can you describe what you did?

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

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

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

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

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

25 A. Yes.

26 Q. Of the staff?

27 A. Yes.

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

29 A. Yes.

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

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

- 1 **Q.** So when you were working in ward 1, what you saw was people appearing to be on the
2 brink of death being treated with vast amounts of antibiotics, but again, there was no
3 activity for them?
- 4 **A.** That's right.
- 5 **Q.** And you recall one woman whose hands were locked due to just sitting with her arms
6 folded for decades?
- 7 **A.** Yeah, she sat like this, and every day her hands were -- fingers were prised open and were
8 painted with Mercurochrome to stop the fungus from growing, and then she would sit like
9 that again.
- 10 **Q.** So for her and other patients, what change did you implement?
- 11 **A.** Well, I'm a pianist, and so the big thing that I did, supported by the OT and the physio, was
12 I went in there for 45 minutes every single day and we played "Roll Out the Barrel" and
13 "The Saints" and all of the old songs and got people moving. And, you know, the
14 responsiveness, we're talking within two or three weeks, people would -- or less, people
15 would start and you'd see them, their eyes open and you'd see a foot tapping and it was sort
16 of inchworm stuff. And you could see the lights coming on, it was just fantastic.
- 17 **Q.** You mentioned you could see the lights coming on. From your experience, what is the
18 importance of physical movement to mental health?
- 19 **A.** It's fundamental, absolutely fundamental. I mean, just look at your child development
20 patterns, you know, your physical movement, sensory mode of development, that becomes
21 the basis for cognitive development, and -- yeah.
- 22 **Q.** So by getting these people moving, their physical health improved, their cognition
23 improved?
- 24 **A.** Yes, and an interesting phenomenon in ward 1 was that, and I don't have -- didn't collect the
25 data, it seemed a bit -- I didn't collect the data formally, but once people were moving and
26 moving consistently, we tended not to have the chronic demise at end of life, people lived
27 better and died quicker, if that makes sense, that was our perception of things.
- 28 **Q.** So effectively people didn't die. Once they were given intervention, that got them moving?
- 29 **A.** They didn't die with the long chronic disablement and deterioration.
- 30 **Q.** Right. You talked in your statement about a patient who'd been found living in a chook
31 house?
- 32 **A.** Yes, yes.
- 33 **Q.** Can you tell us about her?

- 1 A. She was a great lady, and she -- she had cerebral palsy and so she was quite hunched up and
2 constantly looking down and she spoke very, very little. And we got her a job and she
3 worked for a wine and spirits agent and she sat in the front seat and she held a clipboard
4 and after she'd been doing that for two or three months she started to sit up straighter and
5 she started talking to the driver and noticing what was going on. It was fantastic.
- 6 Q. And so that's a concrete example of changing her environment --
- 7 A. Yes.
- 8 Q. -- completely changed her?
- 9 A. Absolutely.
- 10 Q. By the late 1980s, you've noted that there was a group of senior nurses who led a
11 movement for patients to have their own clothing?
- 12 A. That's right.
- 13 Q. So I understand internationally there was a lot of evidence supporting
14 deinstitutionalisation?
- 15 A. That's right.
- 16 Q. And treating people more as individuals?
- 17 A. That's right.
- 18 Q. And obviously the nurses had picked up on this?
- 19 A. I think these particular nurses were quite ahead of their time at that time, and were quite
20 strong on the business of -- I mean, there used to be meetings, national meetings and people
21 decided on the pattern of dresses that would be made next year for the long-term residents,
22 and they had to be careful because if they put an extra dart in then the implications for cost
23 for 2,000 dresses are enormous, and, you know, they said this is ridiculous.
- 24 Q. So throughout the 70s and 80s when you worked at Sunnyside, all the people that you were
25 working with, were all dressed the same?
- 26 A. Through the 70s. I think around about the 80s it will have changed.
- 27 Q. I just want to briefly take you to your experience of Māori patients in care. You said the
28 people that you worked with predominantly in Sunnyside were Pākehā?
- 29 A. That's right.
- 30 Q. But in your statement you do recall -- well, in fact, I'll go back. What your observation
31 was, was in the learning disability area of Sunnyside?
- 32 A. Yes.
- 33 Q. What was called the Mentally Handicapped Area. But, of course, there were other areas of
34 Sunnyside with mental health acute services?

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

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

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

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

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

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

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

18 **A.** Oh, yes, yes.

19 **Q.** Can you describe for us that situation?

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

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

26 **A.** And it's not unusual.

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

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

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

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

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

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

8 **A.** Yes.

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

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

15 **Q.** Not unusual?

16 **A.** Not unusual at all.

17 **Q.** Thank you.

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

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

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

32 **A.** Yes. That's right.

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

1 A. That's right.

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

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

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

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

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

23 A. That's probably a little bit of an oversimplification, but yes. Some of the medications being
24 used now are more targeted towards treating anxiety states, but nevertheless it's a
25 pharmaceutical option to actually sitting down with somebody and finding out what it is
26 that troubles them.

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

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

- 1 medication to get somebody over a hump becomes a long-term solution and so the issue
2 that's generating this is never addressed.
- 3 **Q.** So something that could be very acceptable to manage an acute situation becomes a
4 long-term medication?
- 5 **A.** Yes.
- 6 **Q.** And just briefly --
- 7 **A.** I mean, I think -- can I just add that, to me, the issue comes back to funding and there being
8 just one person responsible for six people and responsible for doing all of those things.
- 9 **Q.** Right.
- 10 **A.** So we are employing people to be jack of all trades and master of none and some of them
11 are absolutely brilliant, but it's a big ask.
- 12 **Q.** And I had skipped over it, but just briefly, your observation in the institutions was that
13 medication at times was used for punishment?
- 14 **A.** Absolutely, absolutely. And in my statement I cited the example of a medical officer -- the
15 same one who had challenged my position -- went out and he'd made somebody angry, it
16 wasn't hard to do, and they'd bent his windscreen wiper and he charged back into the
17 hospital in a rage and increased the person's medication.
- 18 **Q.** And nobody questioned it?
- 19 **A.** No.
- 20 **Q.** I just want to touch on current-day issues. You've said that when you were working for
21 IHC you introduced annual health checks and what the data showed is 73% of people with
22 learning disabilities and autism who were in care, or of disabled people in care with IHC,
23 required significant health interventions, cataract operations, cancer screens, dental work,
24 pain management and more, that -- and they weren't receiving that basic health. You've
25 also told me that in terms of disabled people's mental health that it only gets to when the
26 level of their behaviour is so disturbed they're considered in need of forensic containment,
27 restraint and sedation, that anybody looks after their mental health needs?
- 28 **A.** First things first. In terms of the health -- their health needs --
- 29 **Q.** Dr Webb, can you just pull the microphone a bit closer?
- 30 **A.** Sorry. In terms of their general health needs, we have a particular primary healthcare
31 system that requires us to go to the doctor and complain about what it is that is wrong with
32 us. And that act of complaining requires insight, body awareness, and cognitive and
33 linguistic capacity to do that. And whilst there are a number of medical situations where

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

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

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

7 **A.** Yes.

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

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

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

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

23 **A.** Absolutely. Absolutely.

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

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

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

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

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

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

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

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

21 **Q.** And that's what he wants?

22 **A.** Mmm.

23 **Q.** Individuality?

24 **A.** Mmm.

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

27 **A.** Yeah.

28 **Q.** Provide for them?

29 **A.** Yes.

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

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

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

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

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

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

13 **A.** Mmm.

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

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

19 **Q.** But disabled people are prevented from that?

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

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

22 **A.** No.

23 **Q.** Why is that?

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

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

29 **A.** Yes.

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

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

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

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

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

14 **A.** That's right.

15 **Q.** And what was the outcomes for her?

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

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

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

30 **A.** Yes.

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

- 1 A. No, no, I mean, Tony is considered to be very challenging, and he asserts himself and he
2 asserts himself very positively at times, and he manages to -- he has rules about who's
3 allowed in his room and who's not allowed in his room and that's considered to be quite
4 difficult to cope with at times.
- 5 Q. So he's considered as having challenging behaviours just because he wants to have control
6 who's in his bedroom?
- 7 A. Yeah.
- 8 Q. And this is a 59-year-old man?
- 9 A. Mmm.
- 10 Q. What, just briefly, you've talked about how hard it is to implement change. If you could
11 wave a magic wand, what would you like to see happen in the future for people with
12 learning disabilities and autism?
- 13 A. It's this mixture of listening to people and watching people, and, you know, the most
14 challenging person in the world will have times and places and things in which they're
15 never challenging because they're happy, because they want to be what they --where they
16 are and they want to be doing what they're doing at that time. And it's about getting away
17 from the one size fits all. You know, it's about, you know, our community people,
18 particularly with intellectual disabilities, typically they're not hugged, they're not touched,
19 they don't have an intimate life, and it's sort of, I don't know, it's just about, we have to
20 devolve -- I know that we need our bureaucratic systems for managing and handling
21 funding and all of those sorts of things, but they should come after the intimate assessments
22 and the, you know, really what is it in this world that is going to make this person happy.
23 And we've sort of -- we sort of have shied away from that, I think it's awkward.
- 24 I went to a so-called programme review meeting once and people had a ctually
25 written at the top of the form that they were filling out: "We asked Johnny" or whatever he
26 was "what he would like to do and he said he'd like to go to Disneyland, and we explained
27 to him that that's totally unrealistic. His needs therefore are ..."
- 28 And so the form was filled out.
- 29 Q. So they ignored his wishes?
- 30 A. Mmm. And I just think there's better ways of doing things, even if he couldn't have quite
31 got to Disneyland, he could have got somewhere like it, you know.
- 32 Q. They could have taken the core of his wish --
- 33 A. Mmm.
- 34 Q. -- and seen if that could have been accommodated in some way?

1 A. Mmm.

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

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

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

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

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

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

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

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

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

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

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

23 Q. Thanks, really appreciate that, and I appreciate the strength you feel a bout it.

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

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

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

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

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

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

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

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

15 **Q.** Yes.

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

22 **Q.** Yes.

23 **A.** You know.

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

25 **A.** Yes.

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

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

31 **A.** Mmm.

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

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

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

7 A. Drive slash manipulation, yes.

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

9 A. Whatever it took, yes.

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

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

15 Q. Yes, thank you for that.

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

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

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

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

33 Q. Yes, okay?

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

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

4 A. Yes.

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

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

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

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

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

23 A. Yes.

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

27 A. Mmm.

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

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

- 1 A. No, not doing what was right at the time, but doing what was the order of the time and this
2 was special. I mean, people would go away and they would live with their families and
3 they would come back and they would live that style of living but then they would go to
4 work and they would do this.
- 5 Q. Yes.
- 6 A. It's quite a split -- it's like a parallel, it becomes like a parallel universe.
- 7 Q. But it's a serious issue because, you know, you made the Nazi Germany comparison. We
8 have to be very vigilant, don't we, about this? It's so easy to fall into patterns of behaviour
9 and attitudes just because everyone else around us is doing that?
- 10 A. And it's more than just being vigilant, I think that there is a very real risk that in tough
11 times when the dollar becomes harder to get, that this is the place where people, and I think
12 in my evidence I cite a couple of examples, that this is the default mechanism that we can
13 save money here.
- 14 Q. Yes.
- 15 A. And that to me is hugely risky.
- 16 Q. Or we can give this medication instead of taking a therapeutic approach, the short -- almost
17 the shortcut version?
- 18 A. And I promise you, there will be pressure to do all of those things.
- 19 Q. So that's a challenge, isn't it, for the future?
- 20 A. Not that long ago I was involved, probably when I was working with IHC, I was involved
21 with a very disturbed young man who was a boy and we were trying to find
22 accommodation for him, and a senior person, whose name I don't know which is great,
23 from then Child, Youth and Family, was heard on the end of the phone to say, "For Christ's
24 sake, there must be another four or five of these people around, can't we lump them
25 together and bang them in a house?" And that's the risk.
- 26 Q. And it's almost the reality?
- 27 A. Mmm-hmm.
- 28 Q. You have set us a great challenge, Dr Webb, thank you. I'll leave you now with
29 Commissioner Steenson.
- 30 **COMMISSIONER STEENSON:** Tēnā koe.
- 31 A. Tēnā koe.
- 32 Q. You've had a lot of questions so I'll just keep mine to a minimum, I've only got a couple.
33 But I really want to get your views, because you've got such a lifetime of experience, so
34 I want to take advantage of that.

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

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

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

11 Q. It is.

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

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

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

30 Q. Yes.

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

- 1 **Q.** Thank you. It was a big question so you've answered it really well, thank you. And I think
2 related to that is, I'd like your views on what are some of the social issues that occur by not
3 providing properly-funded services for people with disabilities?
- 4 **A.** It always puts me in mind of the Dr Seuss Star-Belly Sneetches, you know, that have to go
5 through the system and all get the same star in order to succeed. The risks are that we -- the
6 real risk is we go back to exactly what we were doing 40 years ago. That's the real risk.
7 Because if you start ignoring people's humanity, where do you stop?
- 8 **Q.** And what does that say about us?
- 9 **A.** Yeah. And, you know, it's -- and people who have people with disabilities in their lives
10 will know that they are richer because of that, because, if you like, they get a non-tech
11 non-complex expression of -- go back to their humanity, to what they are, you know.
- 12 **Q.** Thank you. Thank you, that's wonderful. You've really provided a wealth of information
13 today from your vast working experience, yeah, and describing the concentration camp like
14 environment at Sunnyside. It's in line with lots of other witnesses' descriptions of these
15 institutions, and just talking about the attitudes like we have held around people with
16 disabilities and how they're being treated. What really stood out for me in your -- in what
17 you've said today is the treatment being based on that animalistic conceptualisation of
18 people with disabilities and being contained and to be restrained and using control and
19 punishment, you know, that "us and them" power and control, rather than the care and the
20 understanding that they deserve.
- 21 So yeah, thank you so much for providing your statement to the Royal Commission
22 today, ngā mihi ki a koe.
- 23 **A.** Thank you.
- 24 **MS BASIRE:** Madam Chair, just before we finish, and I know this is out of order, but yesterday
25 we heard about the drug experiment at Māngere.
- 26 **CHAIR:** Yes.
- 27 **MS BASIRE:** Dr Webb has mentioned to me this morning that she does have some information
28 about that. I could ask a quick question to capture it.
- 29 **CHAIR:** I think it would be appropriate if you are able to do that, we'd really appreciate that, Dr
30 Webb, thank you.
- 31 **QUESTIONING BY MS BASIRE CONTINUED:** Right. Now, without mentioning names,
32 because it hasn't gone through some of our processes, we heard yesterday that at Māngere
33 Hospital, about the same time that you were working at Sunnyside Hospital, there were
34 drug experiments happening on the patients at Māngere. Can you tell us what you

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

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

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

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

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

17 Q. Thank you.

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

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

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

24 **Adjournment from 11.46 am to 12.03 pm**