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

Under	The Inquiries Act 2013
In the matter of	The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions
Royal Commission:	Judge Coral Shaw (Chair) Ali'imuamua Sandra Alofivae Mr Paul Gibson
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton, Mr Andrew Molloy, Ms Ruth Thomas, Ms Finlayson-Davis, for the Royal Commission Ms Karen Feint QC, Ms Julia White and Ms Jane Maltby for the Crown Mrs Frances Joychild QC, Ms Alana Thomas and Tracey Hu for the Survivors Ms Moira Green for the Citizens Commission on Human Rights Ms Susan Hughes QC for Mr Malcolm Burgess and Mr Lawrence Reid Mr Michael Heron QC for Dr Janice Wilson Ms Frances Everard for the New Zealand Human Rights Commission Mr Hayden Rattray for Mr Selwyn Leeks Mr Eric Forster for Victor Soeterik Mr Lester Cordwell for Mr Brian Stabb and Ms Gloria Barr Mr Scott Brickell for Denis Hesseltine Ms Anita Miller for the Medical Council
Venue:	Level 2 Abuse in Care Royal Commission of Inquiry 414 Khyber Pass Road AUCKLAND
Date:	22 June 2021

TRANSCRIPT OF PROCEEDINGS

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MS FINLAYSON-DAVIS: Good afternoon Commissioners. The next witness is Dr David Baron, he's appearing on our screens via video link from Australia.

DAVID BARON

CHAIR: It's probably afternoon in your country Dr Baron.

A. Well, yes, it is, it's just after lunch.

Q. Very good time. Well, welcome to the Royal Commission, I'm Coral Shaw, the Chair, I'm here with my two colleagues. I'm going to ask you before you commence giving your evidence if you would just listen to the affirmation and respond to that.

A. Yes.

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

A. I do, yes.

Q. Thank you very much, I'll leave with you Ms Finlayson-Davis.

QUESTIONING BY MS FINLAYSON-DAVIS: Good afternoon Dr Baron. If we can start by confirm, Dr Baron, that you are currently a psychiatrist in private practice in Australia?

A. Yes, I am.

Q. And you are also a member of the Mental Health Tribunal in Victoria; is that correct?

A. Yes, that's correct, yes.

Q. You graduated with a medical degree in 1964 and you note that at that stage psychiatry was a six week course; is that correct?

A. I was an undergraduate, we were the first group of medical students that actually did psychiatry as a six week course and being a B I was the first, I was in the first group. So that prior to that psychiatry was a sort of almost zoological thing where people were sort of taken out to the Cherry Farm which was in the country and sort of people were sort of, as it were, almost shown as exhibits, whereas we were much more interested in psychological aspects of the profession.

Q. And so if the six weeks was part of your undergraduate degree, did you get further training at a postgraduate level?

A. Yes, yes, yes, I mean we were, you know, I worked at Sunnyside after a while as a registrar, and we had training, sort of a training programme there, it was pretty rudimentary. I actually did a course by mail from Britain so that -- there wasn't much going in New Zealand in those days.

Q. After leaving university I think you had a number of positions both in New Zealand and then in the United Kingdom?

A. Yes.

Q. Before coming back to take up a position at Sunnyside Hospital as a consultant psychiatrist?

A. Yes, that's correct, yes.

Q. And I think you touch on this later, but one of your positions in the United Kingdom was at a Child and Adolescent Unit?

A. There was an adolescent unit in the hospital in which I worked. I didn't work there, but being on-call quite a lot you got a handle on what was going on there because you were there at night and that sort of thing.

Q. Now when you commenced work at Sunnyside you talk about employing a model of care called therapeutic community. Can you help us understand what's involved in that model of care?

A. Well, it's very largely a group care, the whole of the worked on group, group work, so that for instance one would start off in the morning with a big group, all the staff, which included cleaners and people like that, in which you sort of review what had gone on in the night and you'd introduce new people and people would talk about what the issues were currently in the ward. But also any kind of issues related to psychiatry, like, you know, we'd discuss topics like anybody can have a mental illness, that sort of thing, and that was -- so that that -- and then we'd have morning tea and then we'd have small groups in which we dealt more with specific personal things. And that was different to the sort of traditional model in which you had a hierarchical system with the sort of consultant at the top and then the registrars underneath and then the nursing staff etc. So we were very different to what was the traditional model. And in fact I think things have gone back to the traditional model now.

Q. And I should probably have clarified, this was 1970 that you --

A. Yes.

Q. -- commenced this position?

A. Yes.

Q. Were you aware of any other unit or facility employing such a model of care in the 1970s?

A. In Britain, yes, but not in New Zealand. And later on one started up in Melbourne, but there were only a few of them around the world. It's very hard work you know, you know, you're really -- you can't fall back on your authority.

CHAIR: It's hard being democratic, I think that's what you're saying.

A. I'm certain, yes, it is, it is, very hard, yes, yes.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: I think at paragraph 5 of your statement you talk about some of the other types of staff that you had working there, you mention a psychologist, a social worker, an occupation therapist, and they were all part of the team delivering this model.

A. Yes, yes. Yes, there were four wards and two downstairs, one on one side and one on the other, and then an upstairs, and then upstairs we had two other ones, so there are about 30 beds in each one.

Q. Now at some point in time I think you note when medical staffing numbers increased, you turned your mind to the issue of adolescents coming into Sunnyside and at that stage presumably being part of the general unit that you were in rather than their own specific unit?

A. Yes, I'd become concerned at the number of young people in the hospital who were mixed in with everybody else and I didn't really think that was a good idea at all. So that when staffing numbers increased a bit and had a bit more time I developed a unit for them, adolescent unit.

Q. And in terms of physical location, was that separate to the, I think it was called the Ferguson Clinic that housed the adult patients, was it adjacent --

A. Yes.

Q. -- to or attached in any way?

A. No, no, it was the other side of the -- it was in front of the hospital in one of the old wards we sort of converted one of the old wards to that. But we also had a school house that was elsewhere in the grounds. So yeah, so they would go to school during the day.

Q. And I think you employed the therapeutic community approach to this new --

A. Yes.

Q. -- unit?

A. Yes.

Q. Can you tell us a bit more about how that looked in an adolescent unit?

A. Well, it was much the same, we would sort of meet first thing in the morning and talk about whatever was going on and discuss what was happening with the kids and that sort of thing, and then they would go off to school and they'd spend most of the day there. And then they'd come back to the ward in the afternoon, and I don't know what we used to do then, soft of just muck around I think.

Q. At the time that you established this unit, can you give us an idea of numbers and --

A. I think there's probably about 10, it wasn't big, it wasn't big at all.

Q. Was that a mix of boys and girls or --

A. Yes, yes, yes.

Q. I think you note at your statement that you didn't at that stage have any particular specialist experience of working with adolescents or children and nor did the other staff. And I think you talk about how you overcame the lack of training. What did you do?

A. Well, I don't know, we just sort of talked about stuff and read things and, you know, and I talked a bit to Dr Muir in Dunedin who ran the Adolescent Unit there, we used to talk about things a bit. We just -- we tend to just learn on the job.

Q. Would that have been the same for all of the staff in the unit as far as you can recall?

A. Yes, yes, yes. I mean both the charge nurse and the -- and Sylvia, she -- they had children so it wasn't as though they were unused to dealing with younger people.

Q. You mentioned that you spoke to, was it Dr Muir who had a similar type unit in Dunedin?

A. Yes.

Q. Were you in contact with other child and adolescent units around the country, was there a --

A. No, no.

Q. -- collegial sharing of information between the opportunities?

A. No, no. Well, we were rather different. New Zealand was kind of developing a lot in the 60s and 70s and so there was quite a division between those of us who were younger and perhaps more rebellious and read much more, we were much more interested in psychology and sociology rather than actually classifying people into conditions and, you know, we were -- it was a time, you know, when people were just thinking of hospitals differently and they were getting the idea of starting to close them down and there were various models overseas that we were sort of interested in. But we just, yes, we just did it, you know, we just did what we did and learned as we went along.

Q. I think you've told us the numbers of patients at any one time. What was the age range for the unit?

A. Well, they were all at school. From memory, you know, 14, 15, that sort of age, 12, perhaps 13, you know, that sort of age, adolescents.

Q. I think at paragraph 10 you touch on the purpose for admission for at least some of them, noting schizophrenia, and then a note of undifferentiated conditions. Are you able to assist us with the sort of make-up or the basis for admission of patients in that unit, Dr Baron?

A. They were basically, I mean people sort of referred with disturbed behaviour and so they would get very upset, moody, angry, difficult, acting out. Generally speaking, a lot of adolescent behaviour -- adolescents tend to act out their pain which means they inflict it on

the rest of us. So that one's trying to deal all the time with a very, very difficult situation. Diagnostically, I mean there were a few, very few schizophrenia people. Mostly one was looking at sort of what's become known now as prodromal signs, early signs of distress and of course we now know that a lot of them get through it and get over it, and -- from the, you know, the work sort of done in following up children.

CHAIR: Can you say that word again? I didn't hear it.

A. Prodromal.

Q. How do you spell that?

A. P-R-O-D-R-O-M-A-L. It means an early signs, where you're not quite sure what you're looking at but you -- but it's sort of suggestive that it be -- that it could develop into a more serious psychiatric disorder.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: I think you note that some of the first admissions were children or young people that were already in the hospital. You may not be able to --

A. Yes.

Q. -- recall this now Dr Baron, but are you able to comment on the other children that may have come, which referral pathway they might have followed? Was it a family referral, or doctor's referral or perhaps a referral from another Government department, say, for example, Department of Social Welfare?

A. I -- they seem to come mainly from GPs, you know, just people who were identified in the community. I think probably the schools, some of the schools. I think -- I'm sure we got a few from the Department of Social Welfare, but I don't remember that. I used to visit, there was a girls' home called Kingslea which was nearby in Christchurch and I used to visit there a bit to sort of see some of the girls. I don't remember any of them coming to us, though, from there.

Q. I think that at paragraph 12 you note you may have had to admit -- this is at the bottom of that paragraph -- a couple of very disturbed children?

A. We may have, yeah, I don't remember clearly which ones they would have been.

Q. Given the passage of time perhaps unable to recall the details?

A. Yeah.

Q. From paragraph 13 onwards you speak a little bit about the types of treatment that you employed in the unit. Can you tell us a bit about that?

A. Well, we used the standard drugs at that time, you know, which was antidepressants which were Tryptanol and Tofranil and a certain amount of antipsychotic called Promazine and

I guess Stelazine. We used them a bit. Strictly -- I think we must have used more antidepressants. We actually used a few anticonvulsants as well because at that point we were wondering about -- one wondered about children who became very angry and one wondered if they were, what we used to call epileptic equivalents. But it was very hard really, so that really very difficult people we'd give them anticonvulsants like Tegretol, for instance. I never really thought drugs ought to have much of a role.

Q. You mentioned that you found the needs of the patients required you to be there almost daily which meant --

A. Yes.

Q. -- I got to know them well?

A. Yes.

Q. Are you able to expand on that for us, why that was so important?

A. Well, you knew what was going on, otherwise if you're not there you don't know what's going on. And, you know, you develop relationships with them, you know, we had quite -- it was sort of like an unruly family in a way, you know, in that Bill was the dad, Sylvia was the mum and I'm not quite sure what I was. And, you know, it was really very hard, it was very hard work, and quite emotionally draining, you know, they put an awful lot of pressure on you, and, well, yeah -- and we used to, you know, we used to talk a lot, you know, and do stuff, like when they'd go out they'd go to things in the community and that sort of thing.

Q. We've heard in this hearing, Dr Baron, in respect of the Child and Adolescent Unit at Lake Alice that the psychiatrist would come perhaps maybe once or twice a week, sometimes more sometimes less. Are you able to comment on what impact that might have in terms of the running of the unit, not being present every day?

A. Well, you just wouldn't know what was going on. You know, I mean that is the traditional sort of hierarchical system where the psychiatrist or the person at the top gives the orders and people down below are sort of supposed to carry them out. But unfortunately it's one lot of people telling another lot of people what they ought to be doing doesn't really work when we're dealing with psychological issues really.

I mean they had a pretty organic approach there, you know, they sort of thought of these kids as having, I don't know, (inaudible) or disorders or something and they treated them accordingly as though they had something wrong with their brains. A very organic approach, which of course still goes on today, we call it different things, but psychiatrists are still divided into some of us which are more psychologically orientated and others who are more organic and just the profession in terms of drug treatment and other physical

methods of treatment. But I have a -- I'm on the psychological side.

Q. You talk about the use of a seclusion room in the adolescent unit and about the process that would be employed where once the child or adolescent had settled down, you would organise another patient to sit with them. Can you expand on that for us? This is at paragraph 17 of your statement Dr Baron.

A. Yes, I was thinking about that data, particularly after reading, you know, some of the other evidence that you've had. And what we tended to do, we tended to use it more as a time-out situation, you know, if people got absolutely very distressed, you know, you just pop them in one of the single rooms for a while. But it wasn't actually seclusion. We did much more of that over in Ferguson Clinic where we had a series of single rooms that could be locked, but generally speaking were open. And we used to only use them for very short periods of time and if people were really very disturbed. And we used to try and get on top of them with medication. But what one used to do if people were upset, instead of having the doors locked, you'd allocate another patient who was much improved to be with them and sort of look after them so that, you know, they didn't, as it were, run away. Not that they run away, but because they don't -- people don't usually do that, only do that if you lock them in, if you leave the doors open they don't.

So we tended -- so we would tend to operate, anyway, in the adolescent unit by sort of involving the other kids all the time rather than actually stepping in an authoritarian way. But now and then you just had to just seclude, but it was for time-out rather than actual seclusion. We didn't have any facilities for seclusion in the adolescent unit.

Q. I think you've touched on this already, but perhaps if we can -- I can invite you to speak to it again, you -- paragraphs 18 onwards you talk about the particular difficulties or the particular skills required to work with distressed children. Can you speak to that, Dr Baron?

A. Well, I mean it's really very difficult. For a start they don't trust you, so they're trying you out all the time to begin with anyway. And so they -- it takes them quite a long time before they really do trust you, and that is really very difficult. It's what makes working with them exhausting, because it seems the worst of it is that once they're sort of okay they then leave and they're replaced by somebody else, so it's a kind of -- it's an endlessly stressful job, and I mean I was very happy after a couple of years to move on, and I know Bill Burgess, who had been in the Second World War, said he actually would have prepared to have been on the western front rather than actually working in the adolescent unit. It is very, very difficult work, it takes incredible people to do it. Sylvia had much more -- much the best

capacity of dealing with it, but adolescents are very difficult to work with, which is why they --

Q. I think, you know, at the heart of that is putting a significant amount of time in to build presumably the trust that you're speaking of?

A. Yes.

Q. And so establish a therapeutic relationship?

A. Yes, yes.

Q. It requires that time and patience?

A. Yes. And I wondered at the time whether it did -- whether we did any good, but then after I'd left there they would often come back to see me as patients and I realised that, you know, that there had been a very worthwhile job to do, mmm.

Q. I want to turn to your comments on consent as it existed in the 1970s. And particularly what you understood or how you understood consent to be obtained or not obtained during that time period. If you wanted to pick up from sort of paragraph 21 and 22, was that a concept that was employed in the 1970s or adhered to rather?

A. Yes, I was talking about this, you know, having been sort of asked about this, you know, I actually asking a few of the nurses who I still am friendly with, and they sort of said they -- we talked about -- I asked them about ECT and what happened and they said "Well, we never forced anybody, but there was" -- and the ECT was actually prescribed, as it were, by the doctor. But this was a -- I mean voluntary people presumably had to agree. I don't remember much about that. But generally speaking it was the doctor who decided and then it was carried out.

But as I say, the ones that were doing it, they simply didn't actually force anybody, it wasn't like -- when I first started psychiatry, when I first went to Sunnyside it was just atrocious that everybody virtually who came into the hospital was given ECT and they were sort of dragged down from the sort of dormitory into the sort of room, it was a ridiculous way of treating and I know when the person in charge of the ward went away I stopped doing it, and hardly anybody turned out to need, to require ECT.

So that was -- it developed from that, so we then worked to a much more -- it wasn't, as they say, they don't remember actually forcing anybody, which is quite interesting. But --

Q. When you talk about the early days in Sunnyside, is this when you've arrived in 1970 or --

A. Yes.

Q. -- or are you referencing an earlier time?

A. No, I'm going back to when I first started there in, what, 1965 I think, yeah.
Q. And since we've -- you've raised the topic of ECT, and perhaps with reference to your paragraphs from 27 onwards, while you were at Sunnyside in the 1970s, was ECT given modified or unmodified?
A. Oh it was always modified, mmm.
Q. And you understood that, I think you say at paragraph 29, to be the prevailing method throughout New Zealand facilities?
A. I think so, yeah, I think so, we were -- mmm.
Q. Did you use ECT on children or adolescents in the Child and Adolescent Unit?
A. No, no. I didn't really think it was relevant.
Q. And why didn't you think it was relevant, can you help us with that?
A. Well, you're often looking at disturbed behaviour and, you know, that if you spent a bit of time with people it usually settles down. Look I think even these days I don't think very much -- ECT is given very rarely to children I think from what I hear. I know that in Victoria like on the Mental Health Tribunal you always have to -- we have to give permission for patients to have ECT these days and I mean virtually never see children.
Q. I think you speak to -- I think you refer to it as a more rational use of ECT at paragraph 32 being a result of perhaps better nursing or medical practice.
A. Yes, yes.
Q. Do you have any further comment to that?
A. Well, I mean look, ECT has a part to play, I think particularly in certain depressive conditions that don't respond to other methods of treatment, but there can be a tendency to fall back on physical method of treatment, whereas actually you can treat people in other ways, if you have the resources and the skills. And I think that a lot of -- we put an awful lot of emphasis at Sunnyside on good nursing, and I think we had first class nurses. Mainly as a result of the recruiting work that Dame Margaret Bazley had done. You know, she was an incredible force for good.
Q. I want to ask you about another treatment, the use of Paraldehyde -- and I think you cover this at paragraph 33 of your statement -- was Paraldehyde something in use at Sunnyside in the 1970s?
A. I mean I suppose it could have been. We were a very mixed bunch of doctors. I don't think we used it in Ferguson Clinic at all, I don't think. It just wasn't one of those things that ever appeared relevant.
Q. Do we take from that it wasn't used in the Child and Adolescent Unit either?

A. No, no, I'm sure it wasn't, no.

Q. We've heard a lot in this hearing about, or the term "Aversion Therapy". Was that a treatment that you had heard of or were aware of any colleagues utilising in their practice?

A. Oh, yes, yes, yes, yes, one had heard about it. It just didn't -- it just never seemed to me to be reasonable.

Q. Do we take it from that it wasn't something that was practiced in the Child and Adolescent Unit at Sunnyside?

A. Certainly not, no, no. I think the staff would have gone on strike if we'd have tried that.

Q. At paragraph 36, Dr Baron, you say you were not aware of any Electrical Aversion Therapy being used in any of the hospitals that you worked at, and that's not just in New Zealand but in England and Australia. And that you note that most of your professional contemporaries would have been horrified to hear it was happening to children or adolescent patients.

A. Yes, I mean we did sort of hear about it, you know, there were stories, but I don't think -- well, most people I mixed with didn't really, you know, you sort of roll your eyes if you heard about that, you know, you'd think what on earth do they think they're doing. But then that applied to quite a lot of things like deep sleep and that sort of thing which came later, which, you know, it certainly once again had a phase, but, you know -- I suppose the thing was that when you actually worked with people, you know, when you're actually there on the ground, you took a rather different view, you know, because you actually would see the effect of things, not that I saw the effect of aversion, but one certainly saw the effect of deep sleep and that sort of thing, you know, as a -- because one was -- I was always sort of in a hands-on situation rather than looking from above. So, yeah, but sure it went on, but I don't know, the people I knew never really took it seriously, as a, you know, in other words we never thought of -- nobody I knew ever thought of using it.

CHAIR: Sorry, could I just ask a question about that, Doctor?

A. Yes, sorry.

Q. You say when you're working with people you wouldn't have used it and I'm trying to ascertain what you mean by that. Do you mean to say that when faced with a real human being you wouldn't feel capable of applying that sort of therapy? What do you mean, from a human nature point of view?

A. Well, I mean you can't necessarily go by a human nature point of view, but if you're actually working with people you see the effects of what you do.

Q. Yes.

A. So that a lot of things you don't do because you've seen the effects. Okay, the effect may

well be psychologically disturbing or something or other, but you don't see any benefit. I think I need to see benefit.

Q. Yes, and I think that's what I was clumsily trying to say when I said from a human nature point of view, so you wouldn't inflict some of the treatment on unless you saw it was of benefit to the person?

A. That's right, yes. I mean, for instance, you may well sort of suggest somebody has ECT which they may not want, but one expects to see benefit from it, one doesn't expect to go on doing it and seeing no benefit.

Q. Thank you.

QUESTIONING BY MS FINLAYSON-DAVIS CONTINUED: Dr Baron, I asked you earlier about whether there was any collegial contact between the different child and adolescents units in the 1970s and I think you said you did have some contact with Dr Muir who was operating --

A. Yes.

Q. -- in the Dunedin unit.

A. Yes.

Q. In a similar vein, were there conferences held during the course of those years where you might meet with other colleagues to discuss how you were running units, for example, or the treatments that you were using, was that a feature of professional practice during that decade?

A. Well, we had -- the college had sort of quarterly meetings, I think, you know, where we would meet somewhere, but it wasn't specifically related to adolescent psychiatry, there wasn't that much going. So yeah, we were much more isolated than we are now, you know, it was quite difficult to get anywhere.

Q. You mean to physically get somewhere?

A. Yes. Well, you couldn't just fly anywhere for the day, which is what happens now.

Q. Right, or in fact join a Zoom conference, for example?

A. Or do, yeah, yes, this is a great break-through.

Q. I just had one final question for you, Dr Baron. We've heard some evidence in the hearing about the use of ECT to treat epilepsy. Is that something you could comment on in terms of the practice in the 1970s, were you aware of that being considered as a treatment?

A. Yes, I was aware of that, it was actually -- there was a sort of interest in epilepsy then, quite a -- there was quite a lot, I mean the ECT sort of developed from, or convulsive treatment developed from sort of the incorrect observation schizophrenia and epilepsy didn't co-exist,

which is actually incorrect, and that was where -- so they developed -- therapeutic use of ECT developed from there, well it was started off with deep -- with what you call it, with insulin. And, but it -- so it was used, people used it experimentally in a number of different situations. It never made much sense really. It was -- I think it was one of those things that people do for a while because they're trying to sort of make a name for themselves or, you know, do research on something, because particularly at about that time, the EEG was sort of being developed, although people didn't know how to read them, but I don't think it -- I don't think it was much used, I don't think.

Q. Were you aware of it being used in that way in Sunnyside, for example?

A. I don't think it was, I don't remember it being used. Could have been, Shanks or somebody could have. There were kind of people around who we didn't actually approve of, you know, there were differences of opinion about what should be going on and some of us would groan about other people, you know.

Q. Was there any professional avenues for you to raise concerns about colleagues or psychiatrists you were aware of doing things you didn't approve of?

A. I don't think so. We were still -- the establishment was still pretty powerful, you know, you couldn't step too far out of line, except that some people did. It's funny sort of remembering how it used to be. We were a pretty rag-tag profession in those days, I think. And a lot of people worked in it really who didn't have any, you know, they didn't really have any training at all.

Q. And are you talking about psychiatrists in that respect or --

A. Yes, yes, working in psychiatry, not necessarily psychiatrists, but people -- there were quite a lot of medical officers, you know, who were just doctors without any particular background, you know.

Q. So medical doctors, but without having done a specialty?

A. That's right.

Q. In psychiatry?

A. That's right, yes, yes.

Q. Thank you, Dr Baron, I have no further questions for you, but please remain there in case the Commissioners have any questions for you.

CHAIR: I'll just ask Commissioner Gibson, do you have any questions for the Doctor?

COMMISSIONER GIBSON: Just a clarification, Dr Baron, did you say that there were instances where ECT was used potentially for treatment of epilepsy?

A. I think, not that I had personal knowledge of, but one did hear about it, you know, I think

when I had been asked about it in relationship with the Commission, but I did remember it was one of those things that you think oh, yes, there was a time when people, some people were doing that, you know, it was just one of those things, I don't think it was widely used at all.

Q. And just I think you used the word "rag-tag bunch", was there a perhaps a less focus on discipline and professional consistencies and all that than other medical disciplines, other health disciplines would you say?

A. I think you could say there was a labour shortage, so people were sort of -- got jobs for which they really didn't have any, you know, I mean if you take Sunnyside, I can't remember how many beds we had but there must have been about 1,000, so you need quite a, you know, you need quite a lot of -- you need people around to sort of do medical work, and there were quite a few people who really had no training in psychiatry at all.

Q. And you also mentioned Deep Sleep Therapy, perhaps a range of what might be experimental treatments which were used perhaps without an evidence base and you talked about that kind of reflection of seeing actually what happened to patients, people underneath them?

A. Yeah, yeah, for instance, I mean like I -- there was a consultant in Oxford where I worked who was very keen on it, but you know, when one was a junior doctor there, and you were on-call at the weekend, so you'd actually see what happened to people, you know, and when they woke up and they'd be paranoid and all sorts of things, so that you kind of -- your own personal experience of it, my own personal just, you saw what happened, you know, so which actually meant you didn't want to do anything like that.

Q. Was any, as part of the training, you said it was very limited, on hearing that reflecting back actually understanding the perspectives of those who were on the receiving end of a range of treatment, sometimes experimental treatments, to what extent did that make up professional training?

A. You mean did we see things from the patient's point of view?

Q. Well, and as part of your training were you trained to kind of see things from the patient's perspective, how it might be affecting them?

A. I don't think we were actually trained. I mean you can appreciate what they think and what they feel, you know, they talk about it, you don't need training to know that, it's sort of just what you see, you know. Training's been rather funny over the years, you know, it's been -- there's been an awful lot of just picking it up as we went along and reading stuff and talking to people, you know. It's much more organised now, you know, systematically organised

and it didn't used to be.

Q. Thanks, Dr Baron, that's all the questions.

CHAIR: Dr Baron, I've jumped the gun here a little bit and invited Commissioners to ask questions when Ms Feint from the Crown would like to ask you some questions, so I'm going to revert to her now.

A. Yes.

QUESTIONING BY MS FEINT: Kia ora Dr Baron. My name is Karen Feint and I'm appearing for the Crown as the Chair has just said.

A. I can't actually see you. Aah good, good thank you.

Q. You can see me now?

A. I can see you now, yes.

Q. I must say I'm well disposed towards anyone with a purple wall.

A. It's beautiful isn't it, I know.

Q. Can I start by asking you, Dr Baron, about what you say at paragraph 23 of your evidence where you refer to psychiatrists having a lot of unspoken power?

A. Yes.

Q. And it links with a comment one of the psychiatric nurses gave when giving evidence yesterday when they described psychiatrists as omnipotent in that era. I wonder whether you could expand upon that for me please.

A. I think that's certainly -- some are, I mean there was a lot of power. The only thing is that actually as a psychiatrist you don't feel omnipotent, but that's how you're often seen and, yeah, there was a hierarchical system, because I can remember sort of when I came to Australia the superintendent was sort of, I don't know, he was saying something to one of the nurses that clearly upset her and I said to her later "Why did you -- why didn't you stand up for yourself?" And she said "Oh I wouldn't dare." And I said, well, because -- and I said "Yes, well, I know him and you don't, and actually he's the sort of person that you could have said anything you liked to." But there was that -- so it was -- it's a hierarchical system, that's just how it works. And in fact I know -- I mean these days actually doctors even nowadays have an awful lot of power, because -- and it's because people give it to them, you know, and of course a lot of them will, because they can't cope with being questioned will, of course, come down heavy and sort of try and use various things, so it's -- I sort of think it's people who are rather inadequate.

Q. I get the impression, though, that back then it was an era when the judgment of doctors was trusted a lot more than it was -- than it is today?

A. Yes, I think so, yes.

Q. That there's more of a reluctance to criticise doctors, would you think that would be right?

A. I think people criticise them under their breath. Yeah, I think so, I think people -- yeah, yeah, there's an awful lot of criticism of doctors now, isn't there.

Q. I'll explain what I'm driving at, and the thing about this Inquiry that really puzzles me is that back in 1977 Dr Mirams, who was the Director of the division of Mental Health at the Ministry of Health, I think it was the Department of Health then, submitted complaints to both the Police and the New Zealand Medical Council concerning Dr Leeks, in particular allegations of ECT treatment being used as punishment that had been raised with him, and both the Medical Council and the Police investigated and both cases they sought expert opinions of psychiatrists and in both cases the psychiatrists appeared reluctant, they criticised aspects of his practice, but they were reluctant to go further and accuse him of acting unethically. I'm really interested to understand why that might have been the case, because the Medical Council had the power to investigate Dr Leeks' practice if they considered that he was acting unethically or in a way that was not consistent with good medical standards of the day.

A. Yes, I suppose like I guess are you referring to that Dr McLachlan's report?

Q. Yes.

A. Yes, yes. I know, and I read that and I thought, I thought my word, if I had read it back then I would have been infuriated, because it was kind of a whitewash, wasn't it, like if you compare that to, say, Garry Walter's analysis of all the ECT stuff, it's sort of balanced in which he puts different aspects. But this was an agenda of sort of protecting the sort of profession. I suppose it's the sort of thing that went on in the Catholic Church, that the -- it's very hard to -- yeah, when you look back on it you think gosh isn't that amazing. But then I -- we may just diverse slightly, I can remember, say, Keith Sinclair's history of New Zealand in which he talked of the 1949 wharf strike, and Walter Nash, who was the leader of the opposition at that point, actually suggested that the wharfies may have a point and he was absolutely, you know, he was sort of condemned as being absolutely outrageous, that just saying something that you think was just so evident nowadays.

So there was this incredible power, and look I can remember when I got back to New Zealand from England and I was at a medical meeting and they were talking about obesity, but what they were talking about was sort of miles out of line with what was thought overseas. And anyway, I piped up with what current people were thinking and everybody in the room turned around and stared at me and then it went on as though

I hadn't said anything. And that sort of peculiar power where we're afraid to step out of line. It's around today with a different emphasis. It is, when you look at it you think how on earth did that happen? Why did nobody say anything? You couldn't, you know, you couldn't.

Q. To put it bluntly, Dr Baron, it smacks of the medical profession closing ranks, don't you think?

A. Yes, yes.

Q. And I was going to read to you, did you read Professor Roberts' opinion as well, he was the one who gave the expert opinion to the Medical Council?

A. Yes, yes.

Q. Can I just read to you this passage, because I thought this encapsulated exactly what we're talking about. He says:

"If I may go a little beyond the brief which you gave me, I should like to express my concern for Dr Leeks. He is, I suspect, like many of us in medicine, in a situation where he is being called to account for his utilisation of a technique which in the light of the present day no longer is regarded in the same favourable way in which it was at the time which is under consideration."

A. Well, yes, I read that and what I thought was yes, but some of us didn't do it. That was my thought, you know. It's all very well to say these things were being done but we didn't all do it.

Q. Yes, I understand that. At paragraph 30 of your evidence you refer to Dr Dobson.

A. Yes.

Q. And you say that you had regular contact with him and you recall that he used ECT but you do not believe he would have supported the use of ECT with children. And I wanted to ask you about that, because in Dr McLachlan's opinion, are we able to put this up on the screen or do we then lose Dr Baron? Is it easier if I just read. It is number NZP0000791. So this is Dr McLachlan's opinion that he provided to the Police when they were investigating the complaints that Dr Mirams had submitted. And you said you'd read this, Dr Baron? I'm not sure if you'll --

A. Yeah, yeah, I've read this, yeah.

Q. You can see the screen. If we go down to page 2 of that opinion, actually I don't think we can read it on the screen.

CHAIR: Is there a particular part you'd like to highlight Ms Feint?

A. I've got the --

QUESTIONING BY MS FEINT CONTINUED: I can't actually see the screen.

A. I've got it, could you tell me which -- I have it, I have a copy in front of me.

Q. I'm looking at page 2 of his report.

A. Yes.

Q. And he refers there to Dr Dobson giving a report to the annual meeting of the Royal Australian and New Zealand College of Psychiatrists at Hamilton when it is recorded "that he visited Lake Alice Hospital as branch Chairman and was favourably impressed by comments made by patients of the adolescent unit. He considered the fact that Aversion Therapy used up until 1974 was given from the ECT machine although on different circuit, could have been a major source of confusion on 'shock treatment' being used as punishment." End of quote.

I was interested in that passage because it appears that he, from that, that he toured Lake Alice but he didn't have concerns about what he saw when he was there.

A. Yes. Yeah, it's hard to know what to make of that, isn't it.

Q. Yes, it is. I suppose the problem is, how could the authorities like the Police do anything about Dr Leeks if psychiatrists as the experts were not willing to say what he's doing, steps beyond the bounds of ethical treatment and steps beyond the bounds of medical therapeutic practice and is actually ill treatment of patients at Lake Alice?

A. Yes, mmm, I know, it's sort of hard to know what to do, isn't it. Because some people are really very powerful with their opinions, aren't they.

Q. So when you refer to -- you said a little while ago that the establishment was pretty powerful in those days, who do you regard as the establishment? Is it the Royal College of Australian and New Zealand Psychiatrists, is it the New Zealand Medical Council?

A. Well, I mean the Medical Council was always very powerful. I mean when you were down the bottom, you know, when you were an intern and registrar you were very aware that you had very, you know, little power. I mean it's the same, I mean it's the same today where in hospitals people are afraid to step out of line for fear of their future, you know, it's sort of a -- we're dealing with sort of human beings really. It's the sort of thing you sort of get everywhere. Sometimes the things become sort of more democratic. But even then when they become more democratic it's sort of like animal farm, you know, the people that were the victims then become the victimisers.

CHAIR: And some people are more equal than others.

A. That's right. Or like in The Leopard, you know, where the people who rebel finish up becoming indistinguishable from the people that they overthrew. You know --

QUESTIONING BY MS FEINT CONTINUED: Do you think --

A. Sorry.

Q. Sorry to interrupt, please finish your words.

A. No, no, no.

Q. I was going to ask, do you think there was a prevailing culture back then in the 1970s where the New Zealand Medical Council was reluctant to intervene in terms of ethical issues about the practice of clinicians?

A. Probably. I mean as a doctor, most of us are sort of -- feel that the people that make decisions are rather remote from the people that are lower down the pecking order. You know, people will complain, like if you take the College of Psychiatrists today, you know, there are a lot of people who sort of express discontent with the people who are up the top. It's a sort of -- I don't think it's -- it's not confined to doctors. I think you'll probably find the same thing with lawyers wouldn't you.

Q. Touché. I'm conscious of the time, Madam Chair, I should -- I do have lots more questions but I better wrap that up I think. Could I just for the sake of tying another loose end down, ask you one more follow-up question, Dr Baron. Both Dr McLachlan and Professor Roberts said that in 1973 they thought that Aversion Therapy was still an accepted method of treating behavioural disorders, although they recognise that it was going out of fashion by 1977. Do you agree with them about that?

A. Well, I suppose you could say it was accepted, but I would have thought not widely accepted.

Q. Yes, and to be fair, they do say that. Thank you Dr Baron, that's been very helpful. Thank you very much for your evidence.

CHAIR: Thank you Ms Feint. Dr Baron, I've got just a couple of quick questions. One is about the number of children you had at your unit and I believe you said --

A. About ten.

Q. About ten?

A. About ten.

Q. That was hard work and pretty difficult to manage is what your evidence is, just those small numbers?

A. Yes, yes, that's right, yes.

Q. The evidence we've heard about the Lake Alice Child and Adolescent Unit is that there were up to 45 children there.

A. Yes.

Q. Do you want to comment on that on the sheer numbers?

A. Well, it just sounds like a nightmare. I mean it's just an impossible number sort of -- yes, I would hate to work there. And I mean it would take incredible skills to work with that group of people.

Q. Yes.

A. Yes, I mean --

Q. Yeah, so that's a numbers game. Then there's just the last thing, you were a little bit opaque so I'm going to see if I can get you to maybe be more forward and that was --

A. Forthcoming?

Q. No, no, cunning, not.

A. No, I said forthcoming.

Q. Oh forthcoming, forthcoming, yes.

A. Not cunning.

Q. You said you heard noises, you were talking about other sorts -- so you were down there doing your therapeutic model, you were talking to Dr Muir down in Dunedin, you were young progressives and you said you were the young, probably the young Turks, but -- that's my word -- but that implied, doesn't it, that there were another group at least, at least one other person who wasn't one of you who was using other methods. Was that the -- could that have been Dr Leeks?

A. It could have been, yes, not only him, there were other, plenty of other people around, you know, and Dunedin at that point was becoming progressively more psychologically --

Q. But I'm more interested in just what the noises were that you were hearing about other places that perhaps you didn't agree with?

A. Oh, well look one knew, one heard about Lake Alice, one heard about Porirua, which also the same sort of thing went on there, you know, and in fact Sunnyside did, prior to Edwin Hall arriving as Superintendent, it was a time of change and I note some of us, one talks about generations, I think I was part of the angry generation, you know, we were the angry young men, you know, look back in anger, because what was going on made us angry.

Q. Yes.

A. You know --

Q. But I also get the sense -- sorry to interrupt -- I also get the sense that you felt somewhat powerless or unable to do anything to stop it. Would that be right?

A. Yes, yes, yes.

Q. For the sort of reasons that Ms Feint has been talking to us about, the hierarchy?

A. Yes, yes. And I can remember sort of being overcome with rage at some of the things that went on. But, you know.

Q. All right, I'm going to leave it there and just ask for Commissioner Alofivae to ask any questions that she has and then to close the sessional?

COMMISSIONER ALOFIVAE: Thank you Dr Baron, actually all my questions have been asked so I don't have anything further to ask of you. But it has fallen to me to actually express our gratitude and our thanks for your evidence this afternoon. You've certainly outlined for us a very rich history of your own career and how you've contributed on and off back here to your home country of Aotearoa, and I'd really like to express our gratitude for the honesty in your comments and placing your evidence on record for us to take into consideration. Thank you once again and all the best.

CHAIR: Thank you.

A. Thank you very much.

Q. Good afternoon.

A. Good afternoon.

CHAIR: We'll stop then and just take a very short adjournment for our next witness?

MS FINLAYSON-DAVIS: Yes, thank you.

Adjournment from 3.47 pm to 3.59 pm

CHAIR: Welcome back Ms Joychild.

MS JOYCHILD: Tēnā koutou e ngā Kōmihana. This afternoon we have Ms Y, who we are going to call May, and her daughter GRO-B . So we really have three generations in the witness stand. Ms Y's going to first of all read her mother's draft statement, Ms LL, who died before she had finalised it in December last year. And because it was not very detailed she's also going to go to parts of her mother's statement for the Grant Cameron proceedings which was only 20 years after the events. So May, the Chair is going to give you the affirmation.

CHAIR: We have May and who?

MS JOYCHILD: GRO-B .

MS Y FOR MS LL

CHAIR: Thank you, that's what I was trying to work out. So May.

A. Hi.

Q. I'm just going to ask you, do you solemnly, sincerely, and truly declare and affirm that the evidence you give today will be the truth, the whole truth and nothing but the truth?