BEFORE THE UNITED NATIONS HUMAN RIGHTS COMMITTEE

Secreteriat of the Committee Against Torture
UNOG - Office of the High Commission for Human Rights
8-14 Avenue de la Paix
CH - 1211 Geneva 10
Switzerland

IN THE MATTER OF NEW ZEALAND'S 5th PERIODIC REPORT

Additional information to the submission by the Citizens Commission on Human Rights (CCHR) New Zealand for the United Nations Committee Against Torture on Recommendation 11, Allegations of ill-treatment.

April 2012, New Zealand

1. This suplimentary submission from the Citizens Commission on Human Rights (CCHR) New Zealand follows on from their NGO report to the United Nations Committee Against Torture in May 2010 and should be read in conjunction with this. Since that time three significant reports are now available that are relevant to the concluding observations made by the Committee Against Torture for New Zealand's 5th Periodic Review:

> *"Allegations of ill-treatment*
>
> *11. The Committee is concerned that allegations of cruel, inhuman or degrading treatment inflicted by persons acting in an official capacity against children in state institutions, and against patients in psychiatric hospitals have not been investigated, perpetrators not prosecuted, and victims not accorded redress, including adequate compensation and rehabilitation."*

Two of the reports are independent medical opinions based on inquiries into the allegations of psychiatric abuses to children in State care, and the third is a report by a NZ retired High Court Judge; released by New Zealand crown agencies under the Official Information Act 1982. These reports are attached as part of the Appendix.

"The state party should take appropriate measures to ensure that allegations of cruel, inhuman or degrading treatment in the 'historic cases' are investigated promptly and impartially, perpetrators duly prosecuted, and the victims accorded redress, including compensation and rehabilitation."
UN Committee Against Torture

In conjunction with these reports, initialy, CCHR would like to respond briefly to parts of the New Zealand Government's submission to ensure UNCAT has accurate information with which to question and act. This submission discloses evidence we believe is critical to an investigation into these allegations, but which seems has been primarily ignored.

As we have stated previously, as an NGO working on the ground with victims of these abuses, we feel there is a lack of will to confront or acknowledge that they actually fall under the category of cruel, inhuman or degrading treatment and therefore it seems (due to this assumption) the State feels it has no obligation to investigate the cases promptly and impartially, have the perpetrators duly prosecuted, and the victims accorded redress, including compensation and rehabilitation.

The NZ Government submitted that a number of avenues exist for these victims to seek redress, however in practice this is not the case. In reality they are quite restrictive and the victims are up against a formidable government legal defence team. This is a costly and time-exhausting exercise where the victims of such abuse have to try and bring enough evidence to bear to prove the abuse actually occurred, not to mention the legal limitation barriers.

We believe the avenues and proceedings do not address the obligations of the state party as issued by
UNCAT, namely:

> *"The state party should take appropriate measures to ensure that allegations of cruel, inhuman or degrading treatment in the 'historic cases' are investigated promptly and impartially, perpetrators duly prosecuted, and the victims accorded redress, including compensation and rehabilitation."*

2. It is submitted that this reply to the New Zealand Government response should be read in conjunction with the 2001 report of the Lake Alice abuses written by a NZ retired High Court Judge, Sir Rodney Gallen (attached).

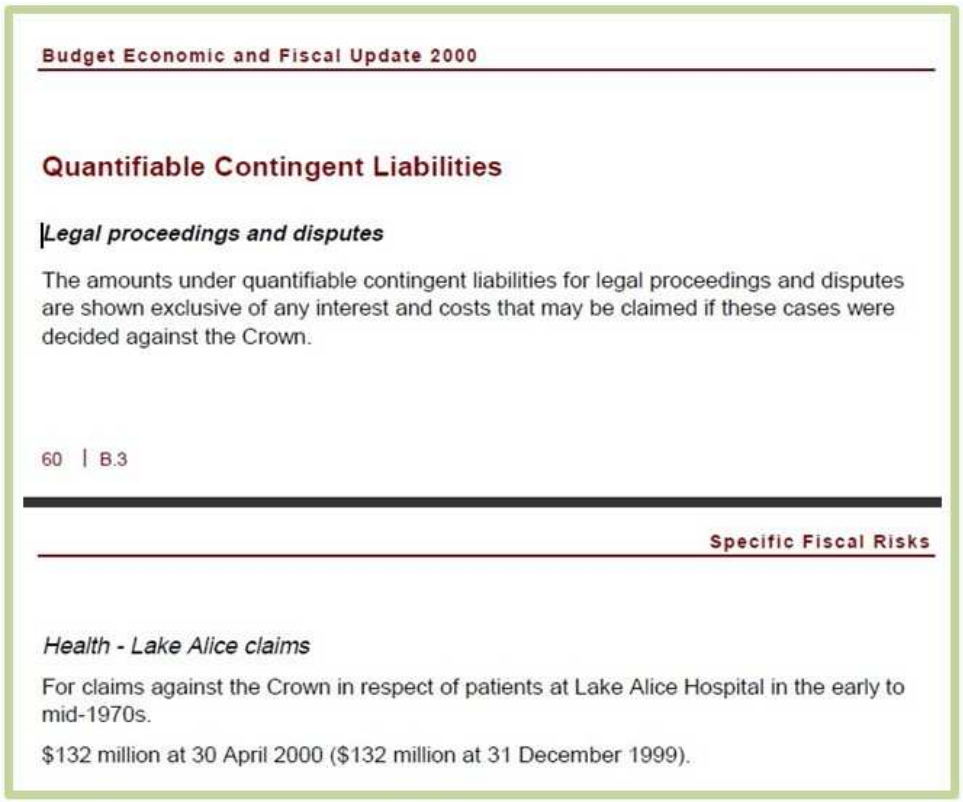
It should be noted that the Gallen Report has only recently been referred to by the NZ Government as having formed part of the Government's 'investigation' into the child psychiatric abuses that occurred at Lake Alice (psychiatric) Hospital. This report covers information relating to 85 individuals who have claimed for the Government payouts. There remains a further 107 individuals who have become claimants.

The Gallen Report does not include any information from the 107 individuals. Sir Rodney was not commissioned to write the report by the state party, but was compelled to publish it due to what he saw and heard from the victims who came forward with their stories. This highlights further the severity and depth of the abuses that were committed by the psychiatrist and mental health staff.

3. The New Zealand Government's response states that:
   "The Government is committed to the investigation and resolution of allegations of torture or ill-treatment by the state."

This has happened to a minor extent with those former Lake Alice victims who have come forward to receive the payouts and a very general apology from the Prime Minister and Minister of Health. However one wonders whether this was merely the mitigation of potentially embarrasing and expensive civil suits, when faced with large numbers of similarly state-abused victims sitting in the wings. What might not be widely known was that there was $132 million liability fund set aside in the NZ Government Budget, just to deal with the Lake Alice cases; of which they settled outside of court, without trial or hearing or precedents or legal liability of ill-treatment or torture, for $6.5 million (below).

The payouts were also ex gratia, not proper compensation and merely settling an out of court civil action against the Government. Accountability of the perpetrators of the ill treatment and torture has never been addressed, which is one common thread expressed by the victims, which would help them gain some closure of what happened.



Budget Economic and Fiscal Update 2000

Quantifiable Contingent Liabilities

Legal proceedings and disputes

The amounts under quantifiable contingent liabilities for legal proceedings and disputes are shown exclusive of any interest and costs that may be claimed if these cases were decided against the Crown.

60 | B.3

Specific Fiscal Risks

Health - Lake Alice claims

For claims against the Crown in respect of patients at Lake Alice Hospital in the early to mid-1970s.

$132 million at 30 April 2000 ($132 million at 31 December 1999).

4. The ex gratia payouts to the first group of 95 victims needed to pay legal fees which were deducted from their payouts. These amounted to approximately 40% of the determined "compensation". When it was realised there were more victims of the abuses, the second group of individuals did not have to pay the legal fees, as the Government said it would take care of their fees. This set up an unfair disadvantage with the first group.

The Government then decided to take a 30% deduction from the second group, however this was illegal, causing more upset. CCHR supported one of the victims to secure the balance of the agreed payout, which took four years, costly lawyers and expensive trips to Wellington from Auckland. (See article below) Even after the court adjudicated the Government should pay up, it took going to the media to run a damning story before they finally furnished the balance. This was estimated to be around $2 million wrongfully withheld across all the victims in the second round.

Though as mentioned above, this does not factor in the 40% legal fees taken out of the first round and the NZ government has not done anything to correct this like they did for the second group. A number of victims and CCHR believe the first group has been unfairly treated with the deductions of the legal fees from their payouts, and feel the government should rectify this, balancing the payouts at the very least.

5. The ill-treatment/torture was carried out by registered doctor/psychiatrist(s) and mental health nursing staff, yet the NZ Medical Council, Nursing Council or health authorities have not carried out their function of protecting children and adolescents against ill treatment and torture by not conducting proper investigations and therefore failing to to take action to prevent the psychiatrist and mental health workers from practicing through to this day. The psychiatrist maintains to this day, that he did no wrong.

6. UNCAT might care to ask the state party what action it is taking against the Medical and Nursing Council's of NZ for failing to take discipliniary action when it knew of ill treatment/torture of children and adolescents at the Lake Alice Hospital Child and Adolescent Unit who were in the care of a registered psychiatrist and nursing staff.

7. The NZ Government response states that:

> *"At a systemic level, allegations of ill-treatment in a given institution are thoroughly investigated."*
>
> *"All affected agencies have commissioned research, as well as looking at individual claims, in order to satisfy themselves that there is no evidence of systemic failure as there was with the Lake Alice psychiatric hospital claims."*

The Government actually admits there is evidence of systemic abuse at Lake Alice yet will not ensure accountability of the perpetrators and provide proper redress. And,

> *"There are two key differences between the current psychiatric hospital claims and the Lake Alice claims which explain the different approach taken by the Government in addressing them. Firstly, the Lake Alice claimants' allegations were factually clearly established. In the current claims, the factual allegations are generally contested. Second, the Lake Alice claimants' allegations were substantially the same in that they related to treatment conditions in the Child and Adolescent ward at Lake Alice, during the period 1972-1977 under the care of one particular doctor."*

Factually, so far there has not been an impartial and thorough investigation completed into the historic abuses as is inferred.

nzherald.co.nz

Lake Alice patient's payout up $34,000

By Martin Johnston
5:00 AM Wednesday Sep 13, 2006

A former patient of the notorious Lake Alice psychiatric hospital near Wanganui has won an increase of more than $34,000 in his payout.

Aucklander Paul Zentveld, 45, has won the top-up in a ruling in which the judge criticises the Crown's position as "Kafkaesque".

Mr Zentveld describes his time in the hospital's child and adolescent unit, spread over five years in the 1970s, as amounting to torture. The unit closed in 1977.

He said he was punished with painful paraldehyde injections and 92 sessions of electric shock therapy and, like many of the young patients, did not have a mental illness.

"They locked me up for five days and nights in a darkened room - solitary confinement."
He is among 183 former patients of the unit to receive from the Government an apology and a share of $10.7 million compensation, divvied up by retired High Court judge Sir Rodney Gallen after considering their evidence of mistreatment.

Their claims included receiving ECT and injections as punishment, sexual abuse, ECT on the genitals in several cases, and one of being locked in a cage with a deranged adult.

Mr Zentveld was given $80,438.60 in 2002, but has successfully sued the Crown for an extra $34,473.68 - plus four years' interest and costs - bringing his compensation to $114,912.28.

This is the sum Sir Rodney, who considered Mr Zentveld's experiences at the unit among the worst he had heard of, had set for him.

The Health Ministry subsequently sliced off 30 per cent. Mr Zentveld and 87 other people with whom the ministry dealt as a second round of claimants received, on average, 30 per cent less than the 95 first-round claimants in 2001. The ministry did this, it said previously, to preserve equity between the two groups.

Around $2.17 million of the $6.5 million paid to the first-round claimants went to their law firm Grant Cameron & Associates in fees and disbursements, according to the Wellington District Court verdict on Mr Zentveld's case, released yesterday.

For the second-round claimants, the ministry appointed David Collins, QC, to assist Sir Rodney and the claimants. Cabinet accordingly decided to slice 30 per cent off the gross compensation, said Judge Tom Broadmore.
The ministry wanted Sir Rodney to make the deductions, but his instructions appear to have been unclear and as a result of a misunderstanding he did not make them.

"It seems clear that [Mr Zentveld] knew that he would not have to pay legal fees because Dr Collins' fees would be paid by the Government," Judge Broadmore says.

"But it is far from clear that he understood that the Government intended ... that the level of net settlements with [second-round] claimants would be lower than for comparable cases [in round one]."

The ministry, when asked last night whether it would appeal or make proportional top-up payments to other second-round claimants, declined to comment. It needed time to analyse the decision, a spokeswoman said.
Mr Zentveld also declined to comment, but his lawyer, Mr Cameron, said his client was "very pleased".

8. The settlement process in the Lake Alice cases provides some redress, though the State is careful to say the money given is not compensation. They also do not work toward bringing any perpetrators prosecuted or held accountable, which is also a requirement in the United Nations Committee recommendation number 11 (see point 1 above).

> ***"CCHR believes an independent body needs to be established, based on the Istanbul Protocol, to look into these abuses of ill treatment and torture."***

9. CCHR believes an independent body needs to be established for psychiatric and institutional abuses (especially via State agencies). Procedures should be based on the Istanbul Protocol, to look into abuses of ill treatment and torture.

Because the State is often implicated in the cases of psychiatric abuse, it cannot be impartial. While there is an admission of systemic abuse at Lake Alice, it seems this was stated to try and distance itself from the other historic abuses (non-Lake Alice), justifying their inaction on ill-treatment and torture allegations.

10. The Committee might care to ask the State what steps are actually being taken to ensure professional accountability occurs. This is crucial when there is such an imbalance of power, and is an essential part of closure for victims of abuse.

11. The report by Sir Rodney Gallen was made *after* the determinations (amounts of ex gratia payouts) for the first 95 child-victims claimed. A further 90+ victims were still to come forward in the "second round" of payouts.

Below are some excerpts from the report compiled by Sir Rodney Gallen, after he had interviewed 41 and read the statements of a further 44 former child-victims who had been in the Child and Adolescent Unit, Lake Alice Hospital.

> *"…what is more, it [ECT] was administered not as a therapy in the ordinary sense of that word, but as a punishment. Claimant after claimant emphasized that the accumulation of unsatisfactory grades during the week meant the likelihood of the administration of ECT at the end of the week in unmodified form. Quite apart from the accumulation of grades, behaviour which was seen as unacceptable, such as running away, generally resulted in the administration of unmodified ECT. The children were familiar with the ECT machine. Quite apart from occasions ECT was administered to them, they were required to assist by bringing it into the room where it was used, and on some occasions actually watched its use on other patients."*

> ***"…what is more, it [ECT] was administered not as a therapy in the ordinary sense of that word, but as a punishment."***
> **Retired High Court Judge, Sir Rodney Gallen.**

"In chilling terms the applicants describe the pain they sustained, sometimes over considerable periods. There are allegations that in some cases the current was administered, increased, reduced and increased again."

"The descriptions which the claimants give of the effect of the increase and reduction, and the time over which the treatment was administered, are detailed and convincing."

"All the children knew when the ECT was being administered, and claimant after claimant speaks of the screaming which was plainly audible to other children in the unit when ECT was administered."

12. If the Government's response statements are correct then it appears that there is knowledge of a further 95 individual's cases of abuse which have not been released. This information would add to the already extremely serious levels of ill treatment/torture of children that occurred as touched on by Sir Rodney Gallen.

Also, this is what the now Crown Solicitor General based his comment on, that if the Police saw the files I have seen (from the second round) they would lay charges.

13. There has been delayed and evasive justice for child victims of ill treatment/torture in New Zealand. The Psychiatrist, Dr Leeks continued practising in Australia since leaving Lake Alice. In around 2002, the Medical Practitioners Board of Victoria, (MPBV) received information of the abuses from a number of the former victims and conducted an investigation. The Board set a date for a formal hearing into the conduct of the psychiatrist. The investigation continued up to the point when the Board were assured the psychiatrist would not practice any longer and therefore no longer be a danger to the public. We believe that investigations in Australia and New Zealand should have gone further as the doctor to this day says he has done no wrong in his now infamous conduct of children in State care.

14. A former registered nurse who worked in the Child and Adolescent Unit at Lake Alice Hospital has recently come forward. Below are excerpts from a statement he made.

"With regards to the use of ECT by Dr. Leeks prior to 1974:

I believe I have an accurate knowledge of what occurred at the Adolescent Unit at Lake Alice regarding the use of ECT. I base this on my memories of specific incidents I clearly recall from that period (Jan 74 –April 74,) from the stories told to me by both the kids I cared for, and the staff I worked with.

Boys were taken from the lounge area to an upstairs side-room which was dark, shuttered... Sometimes this would be done forcibly. Inside the room Dr Leeks would administer electric shocks to various parts of the boy's body over a period of 20 mins. An airway shaped like a mouth gag, was placed in the boy's mouth for him to bite on whilst the shocks were administered. The ECT machine was unusual in that it had a twist regulator on it, with which the operator could vary the intensity and the timing of the shock.

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

"Consent an issue

A large number of the patients were Wards of the State, Dr Leeks duly assumed Guardianship and carried out treatment that he felt appropriate. It was unusual for parents to visit the Unit and it was unusual for Dr Leeks to interview the parents.

Shortly before I began work at Lake Alice there was an inquiry into the Adolescent Unit, conducted by a JP and a lawyer from Marton. The results of that inquiry were in the local newspaper concluding (and I quote) the accusations of mistreatment, 'are just the evil machinations of disturbed children.'

Dr Leeks used the ECT machine as a cruel instrument of punishment and torture. He knew full well that what he was doing was totally wrong.

All Doctors, Nurses, Psychologists and Social Workers would know in their heart that it was wrong.

There is no way it can be rationalized in a civilized society that what he (Dr Leeks) did was treatment. It was torture, nothing less." -Former psychiatric nurse from LA.

15. Independent medical opinions.

There are two significant and revealing reports from an independent medical expert, addressing the psychiatrist and "treatment regimes" used at Lake Alice. These are the expert medical reports obtained for the Medical Practitioners Board of Victoria (Australia) investigation (available only in part to CCHR) and the report made to New Zealand Police (available to CCHR only just last year).

The reports disclose that what was administrered to children in the Child and Adolescent Unit by the psychiatrist appeared to "depart significantly" from the standards of psychiatric care of the day.

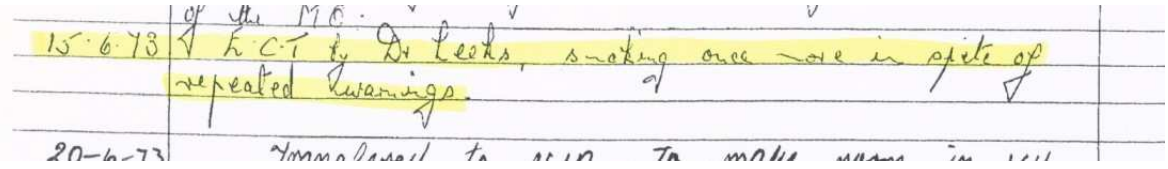
This is extremely important as Dr Leeks, the psychiatrist at the centre of these ill-treatment and torture allegations, utterly denies he did any wrong to this day and that it was "just standard practice" and that the electric shocks were supposedly "below the threshhold of pain" to throw off investigators and officials. This evidence is compelling and completely counters any argument to say the psychiatrist was actually practicing psychiatry or medicine pursuant to the guidelines and practices of the day.

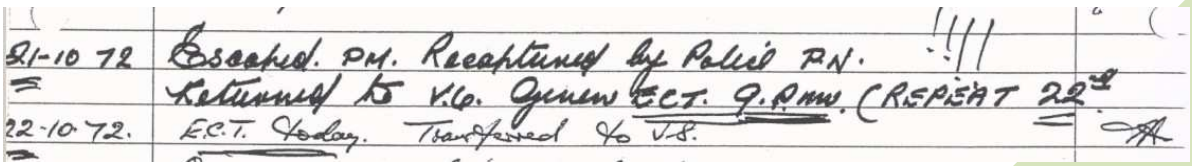
Essentially it seems he had unbridled power, sanctioned by the State, to do what he deemed necessary to "handle" a number of children that had come into the care and protection of the State. This either went unchecked and the psychiatrist was ill-treating on his own; or more feasible and realistic in the public health system, it was known by the State and "sanctioned" by turning a blind eye. With the amount of evidence, publicity, investigations and public outcry over the years, one cannot ignore the lack of action of the State in this extremely serious series of incidents concerning vulnerable children who had already lost usual rights by being in State care.

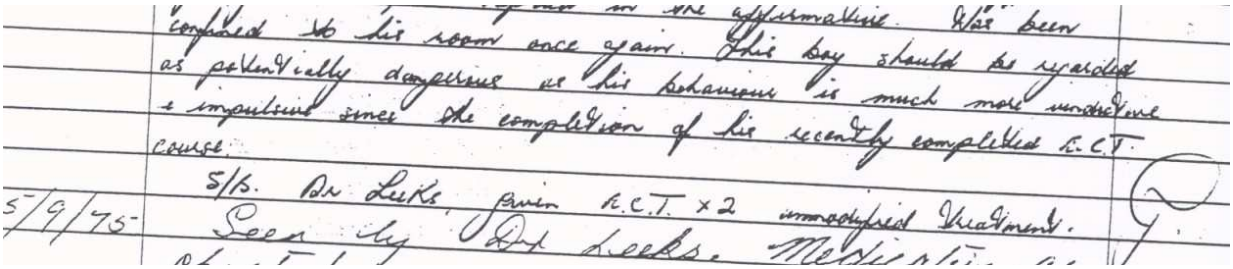
16. The independent medical opinions of Professor Garry Walter said there is no evidence that ECT is an effective treatment for behaviour disorders per se. The medical opinion included:

"It is not, nor has it ever been, appropriate to administer either modified or unmodified ECT to children as a form of punishment. ECT is a medical treatment; it is not a punitive measure nor a means to curb errant behavior."

See below a few excerpts from the child victim nursing notes showing the ill treatment. Painful electric shocks were given for smoking, fighting, running away, etc.

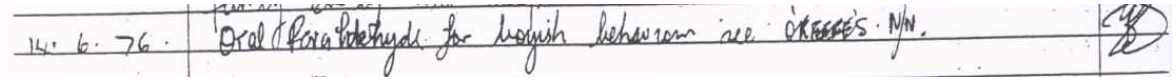

15·6·73 E.C.T by Dr Leeks, smoking once more in spite of repeated warnings.

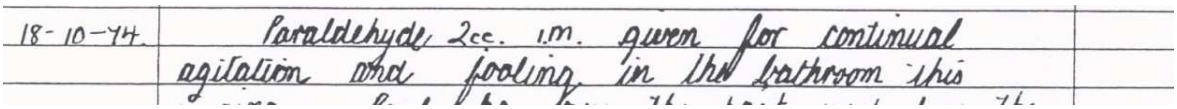

21-10 72 Escaped. PM. Recaptured by Police PN. Returned to V.6. Given E.C.T. 9. P.M. (REPEAT 22nd)
22-10-72. E.C.T. Today. Transferred to V.S.

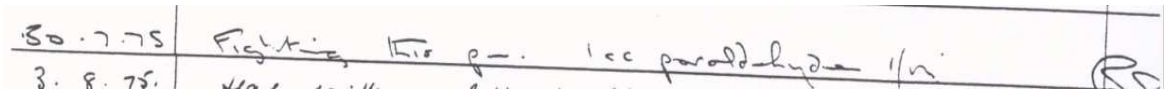

confined to his room once again. This boy should be regarded as potentially dangerous as his behaviour is much more unpredictable + impulsive since the completion of his recently completed E.C.T. course.

5/9/75 S/B. Dr Leeks, given E.C.T. x 2 unmodified treatment. Seen by Dr Leeks. Medication

"Paraldehyde was used as a rapid acting sedative and hypnotic. It was not meant to be used as a punishment for 'misbehaviour' but rather as a treatment for distress and agitation."

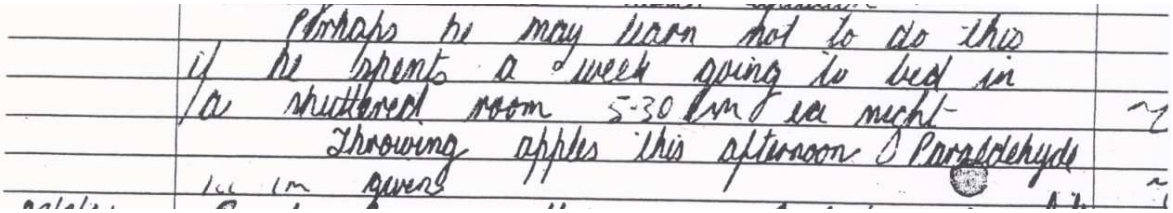

14. 6. 76. Oral Paraldehyde for boyish behaviour see orders. N/N.


18-10-74. Paraldehyde 2cc. i.m. given for continual agitation and fooling in the bathroom this


30.7.75 Fighting. Tries g—. 1cc paraldehyde i/m

3. 8. 75.

Also being locked up in "shuttered room" (seclusion) was threatened and used often.


Perhaps he may learn not to do this if he spents a week going to bed in a shuttered room 5-30 pm ea night- Throwing apples this afternoon 5 Paraldehyde 1cc im given

"The dearth of medical records and nursing notes (ie apart from an admission sheet and examination sheet) for the admission to Lake Alice are a source of disquiet in this case, and perhaps a reflection of the overall standard of care."

"In the 1970s in Western countries it was no longer considered appropriate to administer unmodified ECT, without anaesthetic and relaxant to patients, including children and adolescents." (See appendix for full report).

17. Professor Walter could find no literature specifically on the use of Ectonus in children and adolescents nor on its use as a form of aversion therapy in children and adolescents. Importantly, it had never been medically approved that aversive treatments may be administered via an ECT device, and that aversion therapy has always been controversial.

The concept of patients using electricity to shock other patients (which has been alleged by a number of the child victims) has also never been approved standard practice.

"It was never appropriate in any session where children and adolescents were to administer to fellow patients or offenders electric current, aversion electrical stimulus ECT or using the ectonus technique, because the young patients would not be part of a treatment team. It would be bewildering and traumatic for both the giver and the receiver likely to seriously affect trust in doctors. And for the ones doing the shocks could be interpreted as health staff supporting an aggressive act, and thus giving encouragement for further aggressive acts."

18. Additional comments concerning the psychiatrist calling what he did as so-called "Aversion Therapy", the medical expert says:

"The use of ECT by Dr would not constitute aversion therapy due to a combination of the following factors:

1. *ECT was not a recognized form of aversion therapy (Related to this, it did not appear that Dr was formally evaluating or studying ECT as a type of aversion therapy)*

2. *The specific behaviours that Dr was seeking to abolish were not always clear.*

3. *The level of discomfort reported by patients was extreme, indeed often excruciating, and thus way beyond the pain and discomfort levels described in conventional aversion therapy.*

4. *The patients and families did not consent to ECT (and indeed patients often protested about the use of the treatment).*

5. *The general atmosphere that pervaded the unit and ECT sessions were not 'therapeutic'.*

I note it is alleged that ECT sessions were not always attended exclusively by Dr , Lake Alice staff and the patient; other patients were allegedly sometimes present."

On behalf of the traumatised victims of ill treatment and torture, we ask: if what was being carried out was not standard medical/psychiatric practice, what was it? Surely this would then disconnect those activities with the so-called "therapeutic" environment, much like the builder using his tools of trade (hammer, saw, etc) to harm another. It becomes clear then that this should be a matter of grave criminal concern which the Police should be intensely interested in.

19. After a number of complaints had been made to them, the New Zealand Police also obtained an independent medical opinion from the same Professor of Psychiatry for their investigation into former staff conduct at Lake Alice. This report further described the significant departures of standard medical practice at the time, however the Police didn't act on this. CCHR has only recently become aware that they had this evidence of the cases for all this time.

20. The Police investigation concluded in 2009, saying there was not enough evidence to prosecute and that time limits on making specific criminal complaints were not met. It was a dissapointing outcome. A number of the child victims who had complained were not even interviewed by Police as a part of their criminal investigation. The Police stated one of the victims who complained was deceased but the person was alive and whereabouts known. One wonders what the Police actually did for the eight (8) years they investigated the alleged crimes.

21. Limitation issues relating to psychiatric abuses is quite restricting to this vulnerable group who had aready lost all rights and been severely traumatised by ill treatment/torture as children/adolescents.

As an example, one complaint concerned an incident which occurred around May 1974, in which 5 child victims and 5 former staff were involved in the punishment of another child/youth with the use of an electic shock machine. It was virtually impossible for a complaint to be made within the required legal time frame of 6 months as the complainant, a young boy, was still receiving the ill treatment/torture by mental health staff in the hospital

until December 1975. He made a signed complaint in June 1977 to the Director General of Mental Health. He had been in Lake Alice Hospital against his will.

It is highly unrealistic to expect a young former patient, who mental health staff had labelled, 'adolescent schizophrenia,' 'behaviour disorder with psychopathic personality,' and 'presumed behaviour disorder,' having suffered two years of threats by staff and ill treatment/torture, to be fully cognizant of his rights and precise and exact complaint protocol procedures.

22. The Committee (UNCAT) might seek to ask what inquiry/steps has the NZ Government taken to ensure the former mental health staff are held accountable and what measures have been taken to prevent ill treatment/torture from happening to children by mental health staff in the future?

23. The psychiatrist, Dr Leeks and a few former staff have worked out their careers without a blemish to their record. Most may no longer be registered, however the Medical and Nursing Councils have not made any official statement concerning what happened. There have not been any thorough investigations, censuring, disciplining, restrictions of the former mental health staff, etc. As such this could be interpreted as tacit acceptance of the staff conduct and of who administered ill treatment/torture to the children in their care.

24. To conclude this submission, there have not been any restrictions on any of the procedures used since the abuses happened in the 1970s. Here you have a damning series of incidents occuring to 350-400 children and youth within a State institution, most of whom could clearly be seen to have been ill treated or tortured.

The sheer persistence of the victims to make their stories known and fight for recognition and justice has lead to many others (thousands of men, women and children) coming forward (those who were able) to seek a similar outcome such as UNCAT is suggesting should take place. The State has done little other than try to mitigate the legal and public liability this has toward them; when it would be more ethical and prudent to take a stand and uphold the human rights of victims of cruel, inhuman or degrading treatment.

The New Zealand Human Rights Commission has also recently looked into the huge amount of growing allegations of psychiatric abuse throughout the country; allegations made in the main by people victimised within State institutions. They have written a damning report from all accounts on these issues that CCHR was hoping to comment on prior to sending this update, however it has been held up with the Crown Solicitors for many months. Reviewing the past record of events, what essentially has ended up being the protection of perpetrators of abuse, one wonders what is being done with the report and why it has not been released yet.

Should you wish more information, clarification of any issue, evidence from vicitms themselves, please do not hesitate to contact me.

Yours faithfully,

Steve Green
Executive Director
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REPORT

Introduction

1 Following a television programme which appeared in 1997 a substantial number of people claimed to be entitled to recover damages from the Government as a result of treatment which they alleged they had been subjected to when children at Lake Alice Hospital. Afterwards, proceedings were filed on behalf of a number of claimants by way of class action. A settlement having been negotiated, I was appointed to make a division of the settlement monies between the various claimants. Since that was the limit of my involvement and since, in addition, I was not obliged to indicate the basis of the allocation which I made, and as well the whole was subject to stringent terms of confidentiality, I could dispose of the matter by simply completing the allocation and leaving it at that. For a number of reasons, however, I do not believe that it would be appropriate to dispose of the matter in this way.

2 For the purposes of considering an allocation, I have read the statements of every claimant involved in the case and considered submissions made by legal advisors. In addition, at their request, I have interviewed 41 of the complainants, listened to what they have had to say and checked certain aspects of their statements with them. The vast majority seek some recognition of the sufferings which they claim to have endured during the periods that they were admitted to Lake Alice Hospital and, in addition, almost all seek some kind of apology. I have no power to make an apology, but what I can do is give some indication of my concern at the deeply disturbing and distressing material made available to me. Had there been merely one or two accounts alleging the kind of treatment which is the subject of complaint, it might have been possible to say that these should have been, to some extent, discounted because of the circumstances. In this case there are in excess of 90 accounts, all of which refer to similar circumstances. Many of these corroborate material contained in other statements in circumstances where there could have been no opportunity for the persons making the statements to confer. The vast majority of the complainants do not know who other complainants are, they live in different parts of the country, and some overseas. When, further, there is independent corroboration of material contained in these statements in such medical records as have been retained, then it is not possible to dismiss the complaints in this way. The real question is whether or not to believe the allegations which have been made. I have not been engaged in an inquiry in the usual sense, and in particular I have had no opportunity to seek information from members of the staff directly involved during the period when the complainants were confined at Lake Alice. I have not therefore heard their side of the story. There have already been two inquiries into the situation at Lake Alice, neither of

which refer to the material made available to me, and complaints made by the children at the time to those in authority or parents were discounted. Nevertheless, I am satisfied that in the main the allegations which have been made are true and reveal an appalling situation. Statement after statement, in many cases confirmed on interview, refer to systems, patterns of behaviour, punishments inflicted and a way of life imposed which I have no doubt was established and enforced by those in authority. I should add at this point that not all staff were categorised as cruel and unkind by the complainants. Some went out of their way to indicate that they had received a degree of compassion and understanding from members of the staff, but that the staff members concerned were unable to operate outside a system imposed upon them as well as on the children. This insistence by complainants of drawing attention to people who were kind and compassionate towards them is another factor which tends to add credibility to the accounts which they give.

3 I propose to report in this way. My report is divided into three parts. The first involves a general comment on the situation and procedures complained of in the various statements. This is in general terms and is worded in such a way as to prevent there being any identification of the complainants concerned. I should also say that although the statements contain criticisms of identifiable staff members and other persons associated with the experiences of the children concerned, I have not made any reference to such persons in any way which might identify them. I am aware that many of the complainants would wish this to have been done, but I should stress that in no case have any of these people been confronted with the allegations which have been made, nor have they had any opportunity to endeavour to refute them. Accordingly, I propose to so word my report as to avoid any possibility of identification.

4 Secondly, I propose to indicate the way in which I have approached the method of allocation. I am aware that in terms of my appointment it is unnecessary to do this, but I think the persons concerned are entitled to know the way in which I dealt with this obligation.

5 Finally, the third part of the report deals with the individual allocation. That must remain totally confidential. The advice of the allocations must be made in such a way that no complainant is aware from the allocation of the allocation which has been made to any other complainant. Nor must that part of the report which deals with allocation be made available to any person other than the solicitor acting on behalf of the claimants.

1. GENERAL REPORT

1 The claimants who are now all in their late 30s or early 40s, were when children, by one means or another, placed in the adolescent unit at Lake Alice Hospital in the early 1970s. While there are questions which are concerning from a legal point of view as to the procedures which were adopted when the children were placed in Lake Alice, for the proposes of the allocation, it seems to me that the significant fact is that they were placed there and the means becomes, to some extent, secondary. For that reason I have not taken into account the legalities of placement for the purpose of allocation. Nevertheless, questions which relate to the liberty of the subject are important, and when these relate to people in the helpless position of these children, they should not be forgotten.

2 The children varied in age from the age of 8 years to the age of 16. The average age would have been in the vicinity of 13 or 14. Some children were admitted on a number of occasions, some remained at Lake Alice Hospital for extensive periods, others were there for only a comparatively short time. While some children had been diagnosed as having some form of mental illness, the vast majority were not so diagnosed. They were in fact presenting behaviour problems which for one reason or another were not controllable by the persons who had responsibility for them, nor had those behavioural problems been controlled, in some cases, by placement in other institutions.

3 Some were referred, on medical advice, by their parents, the majority were placed in Lake Alice by State agencies. Some had been subjected to severe physical and sexual abuse before their admission, others had suffered some kind of trauma which affected their ability to integrate into the community of which they were a part.

4 All were in need of understanding, love and compassionate care. That is not what they received at Lake Alice.

5 Lake Alice had been established as an institution for the mentally ill. It contained secure facilities and other facilities for patients which did not need to be kept under secure conditions. It also contained an adolescent unit, and it was this unit where most of the children were placed for some, if not all, of the time they spent at Lake Alice. I observe in passing that although there may have been financial reasons for establishing an institution for the treatment of behavioural problems of adolescents at Lake Alice, it was in most respects a quite inappropriate place to locate such an establishment. Lake Alice had a reputation in the district and beyond it for being a place where the criminally insane were detained. Whether

justified or not it had associated with it a stigma which attached to these children when they returned to the community and which, in many cases, severely restricted their opportunities to reintegrate into the community. They were teased at school and in the community as being mentally ill when they were not, and opportunities which might otherwise have been available to them in terms of employment, were denied them because they were seen as having had a mentally unstable past.

6 From the material contained in the statements, backed up as it is by such medical notes as are available, it appears that the basic theory at Lake Alice in respect of adolescent inmates was that behavioural modification could occur through the imposition of rigid discipline and the application of punishment related to what was seen as unacceptable behaviour. Put in other terms, the theory involved the view that behaviour could be controlled by what is described as "aversion therapy". Certain forms of behaviour resulted in certain consequences, designed to be so unpleasant that the perpetrator would cease behaving in such a way.

7 Such a system is not necessarily a bad one, although one might have reservations about its application to children of the age of these. It is the consequences of failure and the punishments imposed which give rise to major concern. From the moment of their arrival children who were in many cases already upset by being taken from their homes and placed in an unfamiliar environment, were made aware that the slightest failure in achieving the standards considered appropriate by the staff would be met by punishment.

8 The statements and the medical notes make it plain that electroconvulsive therapy was in constant use on the children. Electroconvulsive therapy is a controversial therapy in any event. In the 1970s and earlier it was much more generally used than is the case today. But its only justification is as the name implies: as a therapy. That is not the way in which it was constantly used at Lake Alice. In its acceptable form ECT is applied by way of electrodes attached to the head. The patient is anaesthetised and given a muscle relaxant, and the electric shock administered while the patient is not conscious. Such a form of administration is designated as modified. ECT can also be given unmodified. In certain exceptional cases where medical reasons justify it, unmodified ECT may have had to be given. In such cases the patient is conscious during the administration of the therapy. The application of the electric current causes convulsive movements of the patient's body, which is why a muscle relaxant is desirable, and indeed gives rise unless immediate unconsciousness follows to very severe pain. That is why anaesthesia is in almost all cases appropriate.

9 In 1976 and 1977 a Commission of Inquiry was held into the case of a boy who had been treated with ECT at Lake Alice. The Commissioner was required to deal with a considerable number of matters of complaint, but he dealt in particular

with ECT and its use in general terms in paragraph 4.3. I quote from that paragraph as follows:

> *"Concern was expressed about the application of ECT in an unmodified form and without anaesthetic. As I understand it, treatment in the unmodified form means that no muscle relaxant is used. In the case of children the muscle relaxant does not have the advantages that it has with older people. The purpose of the relaxant is to cut down the severity of the muscular convulsion and minimise the risk of fractures. With children there is less risk of fractures, because their bones are more flexible and their muscles are not developed to the same extent as with adults. The disadvantages of the relaxant are considerable. For one thing, it stops the breathing process and this has to be started again. The evidence is that the risks run in the administration of ECT are linked more with the muscle relaxant than with the treatment itself.*
>
> *Many people react unfavourably to the idea that ECT should ever be administered without an anaesthetic. To an outsider it does not seem humane to fit electrodes to the head of a conscious person and turn on a current, and it is clear that this practice was followed in all but two of the treatments given to the boy. Here again, there seem to be factors for and against the anaesthetic. It is essential to use anaesthetic when the muscle relaxant is given, otherwise the patient becomes alarmed when the breathing process stops. Where muscle relaxant is not used, the same necessity for anaesthetic does not arise. I was assured by the doctors that there is instant loss of consciousness when the current is applied, and that when the patient recovers consciousness he cannot remember receiving the treatment. Added to that there is the undoubted fact that many people, and particularly children, do not like injections. That in itself is a factor to be weighed where the anaesthetic is given only for the patient's comfort. Dr [ ] insisted that in his experience at Lake Alice Hospital children have reacted unfavourable to the anaesthetic and have had a miserable day or two where it has been used. It is clear also that on some occasions when Dr [ ] has to administer this treatment, the anaesthetist is not available.*
>
> *I thought that the discussion on whether anaesthetic should always be used, or whether there are circumstances in which it need not be used, took me out of my depth. I was not persuaded that the treatment was administered in such a way as to cause unnecessary suffering, mental or physical, but if ever an inquiry is set up to consider ECT in general this matter would obviously be considered. I am certain that ECT was not used at Lake Alice Hospital as a punishment."*

The comment that with children there is less risk of fractures because their bones are more flexible and their muscles are not developed to the same extent as with adults, is chilling in the extreme. In fact what the experts were telling the

Commissioner was that bodily reactions which in adults might lead to fractures of the bones and damage to muscles, were not significant to children because of the flexibility of their limbs. Bear in mind that this refers to reactions at a time when the patient, a child, is fully conscious. The Commissioner was told they were rendered instantly unconsciousness. That was not the experience recorded by the complainants in these proceedings.

10 Shortly afterwards an inquiry was conducted by the Ombudsman as a result of a complaint made directly to him. It is unnecessary to refer to the report which was made in detail, but it is appropriate to refer to two paragraphs from the report summary:

> *"31. I discovered a number of disturbing features about the administration of ECT to the boy at Lake Alice, and leaving aside the problem of whether I had the jurisdiction necessary under the Ombudsmen Act 1975, I felt bound to make some comment on the difficult question of the desirability of ECT as a form of treatment administered to children and young persons, particularly in the light of the expert psychiatric opinion I obtained to assist my investigation.*
>
> *32. I was informed that the generally accepted view about the use of ECT with children and adolescents is found in the second edition of the "American Handbook of Psychiatry" edited by Ariti, (published in 1974, Volume 2) page 300 which states:*
>
> > 'There appears to be very little use of electro-convulsive therapy (ECT) in treating the depressive reactions of children and adolescents. During the past ten years, many clinics have discontinued electro-convulsive therapy in adult depression except following an unsuccessful trial of antidepressant medication, or where the suicidal risk is evaluated as being very high, so that the therapeutic time lag that occurs with antidepressive medication is dangerous. At present very few child psychiatrists use electro-convulsive therapy. I would recommend that it be used only as a last resort with adolescents who present a clinical picture of overt depression when psychotherapy and medication have proved ineffective.'
>
> *Although not beyond doubt, I understand that there is a general consensus of opinion and the general practice is that ECT plays little or no part in the treatment of children. It appears to be used, if at all, only as a last resort where other treatments have been exhaustively tried. Unmodified ECT (that is without an anaesthetic and muscle relaxant) in most circumstances cannot be justified."*

11 While in some cases modified ECT was administered on children at Lake Alice, the administration of unmodified ECT was not only common, but routine. That is established not only by the statements of the complainants, but by the medical records which have been made available. The accounts given to me assert, and

the records hospital records confirm, it was not uncommonly given more than once on the same day. One claimant asserts that when that claimant subsequently indicated to a professional man that the claimant had been subjected to unmodified ECT when a child, the person concerned simply refused to believe that anyone had been administering ECT to children at all, let alone unmodified. Unfortunately there is no doubt that it was administered on many occasions to children at Lake Alice during the relevant period. What is more, it was administered not as a therapy in the ordinary sense of that word, but as a punishment. Claimant after claimant emphasised that the accumulation of unsatisfactory grades during the week meant the likelihood of the administration of ECT at the end of the week in an unmodified form. Quite apart from the accumulation of grades, behaviour which was seen as unacceptable, such as running away, generally resulted in the administration of unmodified ECT. The children were familiar with the ECT machine. Quite apart from occasions when ECT was administered to them, they were required to assist by bringing it into the room where it was used, and on some occasions actually watched its use on other patients. Their descriptions of the machine were such that there can be no doubt that they were fully aware of what it was. There are allegations, which I accept, that it was brought into the dining room and placed in a prominent position in order to encourage children to eat their meals if they were reluctant to do so. There are constant claims, which I also accept, that members of the staff would inform children that they were going to receive ECT as a result of certain behaviour.

12 There can be no doubt at all that the children saw the administration of ECT, at least in an unmodified form, as being a punishment and intended to dissuade them from certain forms of conduct.

13 In chilling terms the applicants describe the pain which they sustained, sometimes over considerable periods. There are allegations that in some cases the current was administered, increased, reduced and increased again. The machine as described in statement after statement had a dial and knob which could be turned, allowing the current to be increased or reduced. The descriptions which claimants give of the effect of the increase and reduction, and the time over which the treatment was administered, are detailed and convincing. It is quite apparent that the immediate onset of unconsciousness referred to in the expert literature was rarely the experience of these complainants, but all were aware that it **could** be delivered in a way which resulted in immediate unconsciousness, and when it was so delivered they have stated it. All the children knew when ECT was being administered, and claimant after claimant speaks of the screaming which was plainly audible to other children in the unit when ECT was administered. Although the treatment was administered upstairs in the unit concerned, and the waiting children were downstairs, it is emphasised that the doors were left open. All the children also saw those who were to receive ECT being dragged

screaming and struggling upstairs to the room where the treatment was carried out. They also saw them stumbling down afterwards, often unaided.

14 One of the more distressing aspects of the statements is the number of claimants who referred to children in a terrified group, concerned as to who would be next. There are accounts of staff members selecting children from the group, apparently at random.

15 A number of statements refer to two incidents when particular children who had been the subject of complaints of unacceptable behaviour against other children had unmodified ECT administered to them by those other children, one after the other, under the supervision of the staff.

16 What is even more concerning is the way in which unmodified ECT was administered to parts of the body other than the head. Statement after statement claims that children were subjected to ECT administered to the legs. This seems to have occurred when children had run away from the hospital, and was seen as a deterrent to prevent future attempts to escape. A psychologist who was present at one of the interviews I conducted expressed major concern at this, pointing out that ECT imposed in this way would have inflicted extreme pain. Several claim, and there is corroboration from other unrelated statements, that ECT was administered to the genitals. This seems to have been imposed where the recipient was accused of unacceptable sexual behaviour. I point out that these are children with whom we are concerned. The ECT was plainly delivered as a means of inflicting pain in order to coerce behaviour. ECT delivered in circumstances such as those I have described could not possibly be referred to as therapy, and when administered to defenceless children can only be described as outrageous in the extreme.

17 Reference also should be made to the use of paraldehyde. Paraldehyde is a sedative and one which was once used extensively in order to sedate patients whose behaviour was unacceptable. It is a peculiarly unpleasant sedative and is no longer in general use. It requires the administration of a substantial quantity and it is, when administered by way of injection, extremely painful. The injection itself is painful, and the aftermath leaves a person who has been subjected to such an injection unable to use that part of the body which was used for the purpose of the injection until the effects have worn off, which could take a considerable time. The complainants described the pain as lasting for hours. When given in the leg the child was unable to walk. Mostly it was given in the buttocks, and it was then impossible to sit down for a lengthy period. It was also injected into other parts of the body. One complainant alleges that he was given injections of paraldehyde on the one occasion between each of the fingers of one hand, one after the other. The substance gives rise to a very offensive smell, and leaves an extremely unpleasant taste in the mouth. There can be no doubt that paraldehyde was used by staff

members on their own initiative, without any instruction from medical personnel, whenever the staff member concerned wished to impose a punishment, and on the basis of some of the statements it seems to have been administered on quite a capricious basis. The medical notes themselves indicate that paraldehyde was used as a punishment, and again I should emphasis that we are not here talking about adult or physically difficult patients, but children. Almost every complainant received paraldehyde, and many claim to have had it injected on multiple occasions. The quantities injected are not clear. The medical notes indicate that it was normally injected in quantities of 2cc or more. The statements allege that in most cases when the injection was given in the buttocks two injections were given, one on each side, and there are allegations that sometimes very substantial quantities, such as 10cc, were injected. While the majority of the complainants do not class the administration of paraldehyde in the same category as the administration of ECT, they do regard it as the infliction of severe pain and a matter which has remained of concern to all of them ever since.

18 Solitary confinement was used from time to time as a punishment, and a number of the statements indicate that the children concerned were kept entirely naked while retained in solitary confinement. When in solitary confinement they had a mattress, a bucket for toilet facilities, and nothing else. The reason for this was a fear that the children, if left with clothing, would use it in attempts to commit suicide. The fact that children who were not otherwise mentally disturbed, aged 14 or 15, should be routinely seen as at risk of committing suicide, is of itself a disturbing commentary on the way in which this institution was conducted.

19 Apart from the adolescent unit, Lake Alice was an institution where adults, including the criminally insane, were kept, and for obvious reasons there were secure facilities there. Some of the complainants were placed in an adult villa on admission for varying periods of time. This may have been because there was on any particular occasion no immediate vacancy in the adolescent unit. Nevertheless, it was a wholly inappropriate thing to do. Clearly it was terrifying for children to be kept enclosed in such an environment and they should never have been there. A number complain that they were seriously sexually abused by adult patients while in such a situation, and some have carried the consequences of such behaviour throughout their lives. What is worse, there were undoubtedly occasions when children were threatened with being placed in amongst adult inmates or in maximum security as a punishment for certain forms of behaviour, and it is also clear that children were placed in such situations from time to time. In most cases they were kept apart from adult inmates, but not always. Perhaps the most appalling story contained in all the material placed before me was of a 15 year old boy who claims that he was locked in a wooden cage with a seriously deranged adult who was kept locked in that cage, and who was known to all the people at Lake Alice as being totally insane. He describes a situation where, for a considerable period, he crouched in the corner being pawed by the particular

inmate, screaming to be released, and unable to get out or to get away from the contact to which he had been exposed.

20 A substantial proportion of the claimants were upset in one way or another by association with persons who were plainly mentally deranged. They should never have been in association with them.

21 A number of claimants, both male and female, allege that they were subjected to sexual abuse from staff members or from other inmates, while at Lake Alice. The detail associated with the accounts, together with certain other corroborative material, establishes that behaviour of this kind did occur. They were entitled to be protected against such behaviour, and they are right in claiming that the consequences must have remained with them long after the period they spent at Lake Alice.

22 The best summary which I can make of the large number of statements I have made and the interviews I have conducted is that the children concerned lived in a state of extreme fear and hopelessness. Statement after statement indicates that the child concerned lived in a state of terror during the period they spent at Lake Alice.

23 It is appropriate before leaving these general comments to draw attention to the fact that there were nevertheless some aspects of Lake Alice which were not so bad. Some children, at least, enjoyed the sport and the facilities which were available, and it is noteworthy that a number of members of the staff were referred to in more than one statement with affection and gratitude. Nevertheless, in summary, it has to be said that there is not one single statement which does not indicate that the whole of the subsequent life of the child concerned has been coloured and distorted by the period which he or she spent at an institution which was set up for therapeutic purposes and ought to have provided a haven and means of reformation. It plainly did not.

24 Almost every complainant asks that some system be put in place which would prevent any such situation developing again. As I understand it, there are now safeguards which would achieve this but I suggest thought could be given to requiring any institution of the kind considered here in which a child was placed to advise the Commissioner for Children on admission of any such child.

2. METHOD OF ALLOCATION

1 The claimants were asked how they would approach allocation themselves. A considerable number thought it appropriate that there should be an equal division of the funds made available. One thing is apparent from the statements as a whole, and reflecting upon them. That is, that it was the overall experience at Lake Alice which has been the major concern to every claimant. Even those who were not subjected to the more extreme forms of behaviour modification were subjected to what can only be described as the terror which was a hallmark of the regime as described by the claimants.

2 Few people in the community knew enough of the institution to make a distinction between the adolescent unit and other functions of the institution. Accordingly, both at school and in the community, children who had spent a period there suffered from prejudice and teasing which, in many cases, became cruelty. They were seen as having suffered from mental illness when in the vast majority of cases, they had never suffered from that. That has to be regarded as a significant part of what every one of the claimants endured. More importantly, however, is the atmosphere which was plainly a part of the adolescent unit. Every claimant, whether they suffered from the more extreme forms of treatment or not, emphasised that they lived during their whole time at Lake Alice in what can only be described as terror.

3 Even those children who were completely conformist, lived in a state of abject fear that their behaviour might be seen as not coming up to standard, and that they might suffer ECT on the next ECT day. This was reinforced by what was believed by the children to be the random way in which ECT was actually imposed, apart from those who knew their grades were unacceptable to staff. Claimant after claimant indicated that on one day in the week children were gathered together in the day room and sat there waiting for those to be selected to whom ECT would be applied. Both boys and girls spoke of young children lying in a foetal position on the floor in attempts to avoid being taken up for ECT, and of children who in tears and through sheer fear had lost control of their bodily functions before any application had taken place. Whether they received ECT or not, they all lived in fear of receiving it.

4 Those who had already received unmodified ECT knew what was involved. Those who had not or who never received it, and there were some, were nevertheless in the day room during these periods and were able to hear the screams of children undergoing the ECT in the same building and within earshot. They also were able to see the state of those children when they were returned after ECT. In addition, children were threatened during the course of the week by

staff, and a considerable number of claimants spoke of one staff member at least who was accustomed during the week to place his knuckles on their skull in the place where the ECT terminals would be placed, and they had no doubt whether anything was said or not that this was a threat of the application of ECT.

5 There were also consistent accounts of children being taken by staff to the vicinity of the maximum security wing of the institution and being told that if they misbehaved that is where they would be placed. Since some children actually spent some time in the maximum security wing, this would not have been seen as an idle threat.

6 There was the constant proximity of adult patients whose demented behaviour was a terrifying threat to young children. All of this adds up to an atmosphere which, as much as anything else which happened to these children, led to the trauma from which they then, and in many cases still, suffer.

7 Finally, there was the overall hopelessness of the situation in which the children found themselves. There was literally no way out for them. Those who complained to the staff were seen as troublemakers, and it was the belief of the children concerned that such behaviour led to increased punishment. More than one made complaints to the Police, to probation officers and to child welfare officers. In no case were they believed. Some complained to parents. Some parents complained to the institution, but were told they did not understand the nature of the treatment. Children who ran away were invariably returned and punished for running away.

8 I think it is impossible to escape the conclusion that the experience as a whole was by far the worst aspect of the situation in which these children found themselves, and accordingly I think it is appropriate that there should be an equal division of a substantial proportion of the amounts recovered.

9 Nevertheless, although I have given anxious consideration to the suggestion that there should be an equal division which would reflect the effect of the whole experience of being at Lake Alice, I have come to the conclusion that that would not be just in this case. The experiences of the claimants differ markedly. Some were admitted on more than one occasion. Some spent very much longer periods in the institution than did others. Some were very young on admission. Some were subjected to unmodified ECT, some small number were not. Some had ECT administered to them on other parts of the body than the head, including in some cases the genitals, and that has to be regarded as considerably more serious since it could not be termed therapy. Some did not have paraldehyde administered to them, some had it administered to them on many occasions, and some on quite inappropriate parts of their bodies. I think there has to be a recognition of the fact that some claimants had a very much worse time than others.

10 I have accordingly proceeded on the basis that while a proportion of the total monies made available should be divided equally between all claimants, the balance should be divided unequally to recognise the different experiences of the claimants.

11 In arriving at an allocation of that part unequally divided I have taken into the account the age of the applicants when admitted, the number of admissions, the length of stay, the administration of ECT in one form or another, and the way in which it was administered, the administration of paraldehyde, the use of isolation, and the peculiarly unpleasant experiences which some, but not all, suffered. These things cannot be accurately measured. There is a considerable subjective element involved, and I am aware that different persons might give different weightings to certain of the elements which I have taken into account. I have, however, endeavoured to take into account all of these things and done so against a background of the whole of the statements which I have read and the interviews which have been conducted with those claimants who sought such interviews.

New Zealand POLICE
Nga Pirihimana O Aotearoa

Appendix B

Medical Expert: Professor Garry Walter

28 October 2011

Mr Victor Boyd
Citizens Commission on Human Rights New Zealand
PO Box 5257
Welleseley Street
AUCKLAND

Dear Mr Boyd

I write in response to your request for an Official Information Act dated 17 September 2011.

In your request you asked for a copy of a report prepared by Prof Walter in Jan 2009. You also sought copies of briefing notes and diary notes subsequent to the decision made by me not to prosecute Mr Selwyn Leeks.

Enclosed please find a copy of the report prepared by Professor Walter. The Professor prepared the report for NZ Police. He would prefer it not be released but having taken into account our obligations under the Official Information Act I am releasing it to you. You will note that there is a deletion in paragraph 11, page 8 of the documents. This deletion under section 9(2)(a) of the Official Information Act is to protect the identity of the patient referred to therein.

Your request for information relating to briefing notes or diary notes made at the time, or subsequent to the decision not to prosecute Mr Selwyn Leeks is declined pursuant to section 18(e) of the Official Information Act 1982 as that information does not exist or cannot be found.

You have the right pursuant section 28(3) of the Official Information Act to seek a review of my decision by an Ombudsman

Yours sincerely

Malcolm Burgess
Assistant Commissioner: Investigations and International

Safer Communities Together
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20 January 2009

Mr Malcolm Burgess
Detective Superintendent
New Zealand Police Southern Districts Headquarters
25 Great King Street
Private Bag 1924
Dunedin, New Zealand

Dear Mr Burgess

Re: Lake Alice allegations

Thank you for your letter of 3 October 2008 and attached documentation regarding the alleged activities of Dr Leeks while he was in charge of the Child and Adolescent Unit at Lake Alice Hospital in New Zealand. My answers to your questions are given below. Please do not hesitate to contact me if you would like me to clarify or elaborate upon my answers. I have lumped questions 7 to 10 together. It should also be noted that some of the questions were a little ambiguous, particularly those questions (e.g. question 1) asking for a comparison of "ECT, Ectonus and electric stimuli used as an aversion therapy" (which could mean comparing "ECT" with "Ectonus" with "electric stimuli used as an aversion therapy" ***or*** comparing "ECT used as an aversion therapy" with "Ectonus used as an aversion therapy" with "electric stimuli used as an aversion therapy" - I have interpreted these questions in the former sense).

1. **Describe the difference between ECT, Ectonus and electric stimuli used as an aversion therapy.**

Electroconvulsive therapy (ECT) is a recognized medical treatment. It involves the production of a seizure (convulsion), via the application of an electrical current, to produce positive change in a patient's clinical condition. To achieve this positive change, ECT is delivered as a course of treatment. Often this course will entail treatments delivered two or three times weekly to a total of 6-12 treatments, but the number of treatments in a course can fall outside this range.

"Ectonus" is the name of an ECT device. In the Royal College of Psychiatrists ECT Handbook (Second Report, 1995, page 122), the UK company, Ectron Ltd, is mentioned as producing the "Ectonus".

I am not aware of, nor - following an extensive search of medical databases - could I find reference to a treatment specifically called "Ectonus treatment" or "Ectonus therapy". A small number of papers in the 1950s and 1960s (e.g. Barker and Baker, 1959; Macdougall, 1960) refer to the "ectonus technique". The extent

of use of this technique is not clear, but it does not appear that it was embraced by the psychiatric community nor thoroughly evaluated. The ectonus technique was developed in 1956 by Russell, who also developed a machine for its application. Apparently, the outstanding feature of the ectonus technique was that the patient does not have a full convulsion; the patient has a sustained tonic phase but no (or few) clonic convulsions [note: a normal seizure is said to have "tonic" and "clonic" phases]. The patient would apparently lose consciousness on application of the stimulus. The stimulus would usually be applied for up to 60 seconds, during which time the therapist would alter the voltage (apparently to reduce or negate clonic movements). It is not clear from the literature whether anaesthetic and muscle relaxant were routinely used for the ectonus technique. The clinical situations in which the ectonus technique was used were broadly similar to those for which ECT was used [described in the answer to question 3 below].

Aversion therapy is a treatment intended to reduce unwanted or dangerous behaviour by pairing that behaviour with unpleasant sensations. Aversion therapy has been the focus of debate for many years among educators, mental health practitioners and medical professionals. In many instances, its use remains controversial on ethical grounds and because of concerns about its effectiveness and safety. The method was first used in 1935 to treat homosexuality; an electric current was used for this purpose (and may be termed in this context an **aversion electrical stimulus**). In subsequent years, aversion therapy has been used for homosexuality, sexual disturbances and alcoholism, among other conditions. It would appear that aversion therapy has been used less commonly in young people compared to adults. Aversive stimuli have included electric shock, nausea-inducing drugs (such as Antabuse for alcoholism) and substances (such as ammonia) that produce noxious odours or unpleasant tastes. It is not usual to use an anaesthetic or muscle relaxant as part of the aversion therapy procedure.

2. Describe the appropriate methods of application and the equipment used in the provision of these treatments in the period 1970-1977

The appropriate method of application of **ECT** was predicated on, and entailed:
(i) administration for a recognized clinical indication (for ECT, covered in answer to question 3 below);
(ii) obtaining informed consent; and
(iii) using agreed treatment methods (these treatment methods would include the use of anaesthetic and muscle relaxant, an ECT machine that is able to deliver the electrical current safely and using conventional electrical stimulus parameters, electrode placement in a conventional location, giving a *course* of treatment, monitoring side effects and effectiveness of treatment in the course, and adequate medical care in the immediate postoperative period).

It should be noted that ECT machines were commercially produced in that period. In the decade following the introduction of ECT (the 1940s), some of the ECT machines were made locally by those administering the treatment and their associates, for local use.

The **Ectonus device** and **"Ectonus technique"** have been covered in the answer to question 1.

There were various methods of application of **"aversion electrical stimuli"**. For example, the paper "Aversion Therapy by Electric Shock: a simple technique" (McGuire RJ, Vallance M, *British Medical Journal*, 1964) describes how an apparatus may be built. Critically, compared to ECT and the Ectonus technique mentioned above, the stimulus was much weaker (in the McGuire and Vallance paper, 9 volts), the patient is awake throughout the procedure (essential so that the behaviour being targeted could be consciously paired with an unpleasant sensation, in this case an electric stimulus) and the potential side effects of the treatment were much milder.

It should be noted that there were no "appropriate methods of application" in situations where ECT, ectonus or "aversion electrical stimuli" were administered in a form not recognized as a medical treatment.

3. What was the general medical opinion and practice regarding the use of ECT on children and/or adolescent in the period 1970-1977?

ECT was first administered to children and adolescents in the 1940s by Heuyer and colleagues in Paris. By the 1970s, general medical opinion and practice was that the situations in which ECT was medically warranted (i.e. indicated) in children and adolescents were similar to those situations in which ECT was medically warranted in adults. These situations can be considered in two ways: (1) according to whether ECT was used as first line treatment or not; (2) according to diagnosis. These will be addressed in turn:

ECT as the initial treatment choice

Situations in which ECT may have been warranted as first line treatment included:

1. where there was a need for rapid or definitive response (e.g. the patient was having unrelenting suicidal thoughts and plans and/or refused to drink or eat).
2. where alternative treatments were riskier than ECT.
3. where there was a history of poor medication or good ECT response.
4. where the patient preferred to have ECT.

"Secondary" use of ECT

Situations in which ECT may have been warranted after other treatments were tried first included:

1. where the initial choice of treatment failed.
2. where adverse effects of other treatment proved to be too severe.
3. where the patient's condition was deteriorating rapidly.

Diagnostic indications for ECT

Although, historically, the first patients to receive ECT were those with schizophrenia, it soon became apparent that the major benefits of the treatment were to be seen in persons with depressive illness. Thus, the primary indication

for ECT in the 1970s was severe depression (now known as "major depression"). ECT was found to be useful in those depressed patients who did not respond to medication, and also in those who required a more rapid rate of response than medication could provide, because there was risk of self-harm or persistent refusal to take food or fluids. (ECT has a more rapid rate of response than antidepressant medication). ECT was also found to be useful in severe depressive subtypes – melancholic depression and psychotic depression – which are less likely to respond to medication alone.

Another diagnostic indication for ECT was mania. (In mania, the clinical response to ECT is at least equivalent to that of lithium therapy and ECT is effective in manic patients resistant to pharmacotherapy.)

In acute schizophrenia, ECT has rarely been employed as first-line treatment but the literature suggests that, over the years, it has proved useful in some groups of patients. ECT has generally not been found to be of therapeutic benefit in chronic schizophrenia but it has been argued (e.g. Fink and Sackeim, 1996) that such patients should not be denied a trial of ECT.

ECT has also been used to treat patients with schizophreniform disorder. In the 1970s, as at present, catatonia was an indication for ECT. ECT may also be helpful in other conditions such as neuroleptic malignant syndrome and Parkinson' Disease; the latter is less relevant to young people.

4. What was the medical opinion on the symptoms that might properly be treated by the application of ECT in that time?

Medical opinion was that the symptoms should be *symptoms of the disorder for which ECT was indicated.* In other words, ECT was (and is) a treatment for a psychiatric *disorder*, not (isolated) psychiatric or other *symptoms* (like "disobedience" or "absconding" for example). Because ECT may be (appropriately) administered for a variety of disorders, as mentioned in the answer to question 3 above, it follows that there are numerous potential symptoms – constituting a variety of disorders – for which ECT might have been given.

5. What was the method generally used to administer ECT in children and adolescents?

The patient would be administered a general anaesthetic and muscle relaxant by trained staff, and then an electrical stimulus would be applied, also by trained staff, via electrodes placed on the scalp in a recognized location. This would result in a generalized seizure. There would then be medical and nursing supervision and care in the postoperative period. As mentioned in the answer to question 1, ECT was (and is still presently) delivered as a *course* of treatment to the patient. Often this course entails treatments delivered two or three times weekly to a total of 6-12 treatments, but the number of treatments in a course (and occasionally frequency of treatments per week) can fall outside this range.

6. **Is there, or was there then, any sound rationale for the application of unmodified ECT to children or adolescents?**

ECT was first introduced in 1938 and within a year of its use, the advantages of administering an anaesthetic and muscle relaxant for the treatment were being considered in the literature and seen in some patients. In the 1940s, the practice and recommendations were inconsistent (i.e. some ECT patients received neither anaesthetic nor muscle relaxant, some received anaesthetic but not muscle relaxant, some received muscle relaxant but no anaesthetic, some received both anaesthetic and muscle relaxant). It was not until succinyl choline (a muscle relaxant) was introduced by Holmberg and Thesleff in 1951 that the use of both anaesthetic and muscle relaxant as a prelude to ECT began to achieve wider usage. In the 1950s, the practice became progressively more widespread (for example, in 1957 a survey of 55 hospitals in the UK found that anaesthetic was used in 60% cases of ECT and muscle relaxant in 85% cases); by the 1960s it was standard practice. The following decade, the published literature on ECT included formal recommendations and more surveys of practice.

In the 1970s, in Western countries, it was no longer considered appropriate to administer unmodified ECT (i.e. ECT without anaesthetic and muscle relaxant) to patients, including children and adolescents. Data supporting this statement are as follows:

i) A survey sent out to all government psychiatric hospitals and departments in Denmark in December 1973 found that all sites routinely administered anaesthetics and muscle relaxants for ECT (Heshe and Roeder, 1976).

ii) The Royal College of Psychiatrists issued a detailed memorandum on the use of ECT in 1977. Under Part II ("Standards of administration"), it is stated that "every patient having ECT should be anaesthetised and given a muscle relaxant by an anaesthetist". In 1980-81, data were obtained about 90% of the nearly 400 sites that gave ECT in Great Britain: it was found that "short-acting anaesthetics and muscle relaxants were used in almost all cases" (Pippard and Ellam, 1981).

iii) As part of the work undertaken by the Task Force on ECT of the American Psychiatric Association (APA), a survey on ECT of 4013 members of the APA (20% of the membership) was conducted to ascertain attitudes towards ECT and use of the treatment (APA, 1978). Replies were received from 2973 members (74% of the sample). Of the ECT "users" (22% of respondents), 95% reported generally using a short-acting anaesthetic before administering ECT and 96% reported that all of their ECT patients (during the previous 6 months) had been given a muscle relaxant drug before the ECT was administered.

The Task Force provided "suggested procedures" for administering ECT, at the end of which it has a brief section, "Alternative Procedures", which is as follows: "Although the Task Force recognises that procedures are

frequently used which differ in one or more details from that which is described above and that may be equally acceptable and have a comparable degree of safety, we regard as essential to safe and acceptable ECT the following procedural details:

1. the administration of an anaesthetic agent
2. the administration of muscle relaxant, and
3. oxygen supplementation

I have contacted one of the members of the Taskforce to ask why not all practitioners might have used anaesthetic and muscle relaxant at the time, as revealed by the survey. He mentioned that some clinicians then believed that the anaesthetic lessened the effectiveness of the treatment, particularly in the elderly. He added that muscle relaxants were still being investigated at the time and that there was not the range of muscle relaxants that exist today.

In November 1986, the ECT guidelines of the Royal Australian and New Zealand College of Psychiatrists stated: "we believe that, in general, there is no place in current clinical practice for the administration of unmodified ECT, but that rare exceptions might arise". There is no discussion of what these rare exceptions might have been.

iv) A perusal by me of files of [adult] patients who had ECT at Callan Park Hospital (later Rozelle Hospital) in Sydney, NSW in the 1970s, revealed that modified ECT was used in all cases.

v) The clear recommendation for modified ECT in the 1970s was based on recognition of the adverse effects of unmodified ECT, namely fractures and dislocations, and patient awareness of the treatment.

Fractures and dislocations

Fractures and dislocations were well recognised complications of unmodified ECT. In most cases, these occurred at the onset of the "tonic" phase of the seizure which commenced more abruptly than in spontaneous epileptic attacks. The commonest of the complications was dislocation of the jaw. This would often relocate itself once the convulsion ceased but if not, could almost always be easily reduced in the period following the seizure when muscle relaxation was profound. It was usually followed by stiffness and tenderness of the jaw muscles. Dislocation of the shoulder could also occur. Fractures of the neck of femur, of one or both acetabula (with the heads of the femurs being driven into the pelvis), of the scapula or of the humerus (either a fracture of the neck or a spiral fracture of the shaft) were documented complications. Crush fractures of the vertebra could also occur. The most common was crush fracture of the fifth thoracic vertebra but crush fractures of the fourth, sixth, seventh and eighth were also reported.

Patient awareness of the treatment
Unmodified ECT normally rendered the patient unconscious. However, if the current was not sufficient to cause an immediate unconscious state, the patient could have a number of stressful sensations and experiences, including severe pain in the head, flashes of light if the current was close to the optic nerve, aura, partial insight, experience of the fear of death, perception of rhythmical movements, perception of respiration, and choking.

7. **What was the general medical opinion and practice regarding the use of Ectonus or electrical stimuli as a form of aversion therapy on children and/or adolescents in the period 1970-1977?**

8. **Is there, or was there then, any sound rationale for the application of Ectonus or electrical stimuli to children or adolescents?**

9. **What was the medical opinion on the symptoms or behaviours that might properly be treated by the application of Ectonus or electric stimuli in that time?**

10. **What was the method or equipments generally used to administer Ectonus or electric stimuli? Were these methods used in children and adolescents?**

I could find no literature specifically on the use of Ectonus in children and adolescents (nor on its use as a form of aversion therapy in children and adolescents); general information on Ectonus is given in the answers above.

Although the literature is limited, it would appear that electrical stimuli have been used as a form of aversion therapy for children and adolescents for several decades. A range of potential behaviours have been targeted and these include behaviours (oppositionality, conduct problems, impulsivity etc) that may represent so-called "behavior disorders". Importantly, it has *never* been medically approved that these aversive treatments may be administered via an ECT device/Ectonus, as (i) the degree of discomfort and side effects would have been excessive compared to standard aversion therapy, and (ii) the theory underpinning aversion therapy requires the patient to be awake during the procedure (ECT generally renders the patient unconscious). Stated otherwise, the use of ECT by Dr Leeks would not constitute aversion therapy due to a combination of the following factors:

1. ECT was not a recognized form of aversion therapy (Related to this, I presume that Dr Leeks was not formally evaluating or studying ECT as a type of aversion therapy).
2. The specific behaviours that Dr Leeks was seeking to abolish were not always clear.

3. The level of discomfort reported by patients was presumably extreme, and thus way beyond the pain and discomfort levels described in conventional aversion therapy.
4. The patients and families presumably did not consent to ECT for this purpose (and indeed may have protested about use of the treatment).
5. The general atmosphere that may have pervaded the unit and ECT sessions were possibly not "therapeutic".

It should be mentioned that the person administering (electrical, but non-ECT) aversion therapy has not always had a medical background and the setting has not always been "medical" (office or hospital). It should also be noted that aversion therapy (administered to adults or children/adolescents) has always been controversial (a relevant recent case is described in http://edition.cnn.com/CNN/Programs/anderson.cooper.360/blog/2006/03/shock-therapy-for-kids.html). There is negligible evidence suggesting that (electrical) aversion therapy has long term positive benefits.

11. Was the practice of applying electrodes to parts of the body associated with the "offending behavior" accepted practice?

This has never been accepted practice. In ECT, it has only ever been recommended that the electrodes are applied to the patient's head. I note, for example, that [redacted] alleged that ECT was administered to his knees and genitals. This would have been inappropriate because:

1. There is no evidence base for this being an effective treatment method (e.g. in the case of electroconvulsive therapy, application of the electrical stimulus to the genital area would not produce a convulsion).
2. There may be medical risks associated with the procedure, including to the genital area.
3. Patients would regard this as a procedure whose primary purpose was to punish, rather than to treat.
4. There may be longer term serious psychological complications (including flashbacks, nightmares, etc) associated with such an invasive act.
5. For those patients with a history of sexual abuse (including childhood sexual abuse) this would bring back painful memories of that abuse.

Application of ECT to a limb would be inappropriate because:

1. There is no evidence base for this being an effective treatment method (and the application of the electrical stimulus to a limb would not produce a convulsion).
2. There may be medical risks associated with the procedure, including to the area of application.
3. Patients would regard this as a procedure whose primary purpose was to punish, rather than to treat.
4. There may be longer term serious psychological complications associated with such an act.

Indeed, application of ECT to any part of the body other than the head would be inappropriate for reasons such as those given above.

12. Is there or was there then any sound rationale for inviting children who were victims of offending by the patient to apply electric stimuli to the patient/offender as part of an aversion therapy

It was never appropriate for a doctor to permit children and adolescents (whether or not they were victims of offending) to administer to fellow patients or offenders electric current, aversion electrical stimulus, electroconvulsive therapy, or use the ectonus technique, for several reasons:

1. The children/adolescent patients would not be part of the treatment team.
2. Training and expertise are required to administer treatments. The likelihood of ineffective treatment and the risks of adverse events would be greater if administration was by child or adolescent patients.
3. This would have been bewildering and traumatic, both in the short and longer term, for both the recipient (to witness their treatment being administered by a peer/friend and fellow child/adolescent patient) and child/adolescent patient administering the treatment. One of the likely long-term consequences would be reduced trust in doctors and other health care professionals for both the recipient and person administering the treatment.
4. For the child/adolescent administering the treatment, this action could be interpreted as health staff supporting an aggressive act, and thus giving encouragement for further aggressive acts by that adolescent.

Two further points here:

1. There is a literature on "shame aversion therapy" which involves subjecting the patient to public shame or humiliation in conjunction with his or her deviant behaviour. Only a few cases of shame aversion therapy have been reported; in one, a transvestite attempted suicide after a treatment session. In any event, there is no literature on the use of an electrical stimulus or ECT as a type of "shame aversion therapy", and no mention of children or adolescents participating in such treatment.
2. The "Therapeutic Community" treatment approach uses peer influence, through a variety of group processes, to help individuals learn social norms and develop more effective social skills. Again, however, there is no mention in the literature of extending the application of the "Therapeutic Community" to electrical treatments.

13. What records would one expect to locate regarding these various forms of treatment?

Although the standards of record keeping were neither as high as they are today and the record keeping was less comprehensive, as a bare minimum one would expect for there to be an entry in the patient file on the day of treatment about the treatment being given and any significant untoward effects

experienced following the treatment. Some (but not all) hospitals at the time had a separate form (included in the patient file) that included the date of ECT administration, some information about the characteristics of the electrical stimulus (e.g. on what part of the head the electrodes were applied) and name and doses of medications (anaesthetic, muscle relaxant) used.

14. A general summary of how the treatments described compared to acceptable medical practice in 1970-1977.

In summary, Dr Leeks' treatments appeared to depart significantly from the standards of the day. This was in the areas of his direct clinical care (including his method of use of electrical treatments, and his dubious reasons for some of those treatments), his level of supervision of staff (including the various treatments used by those staff), and his documentation (the last even by 1970s standards). It is worth adding that it appears difficult to ascertain what governed Dr Leeks' decision-making (e.g. when to give patients modified versus unmodified ECT, not that the latter is ever medically indicated).

I trust this report is helpful. Again, please contact me if clarification or elaboration is required.

Yours sincerely

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Appendix C

Victim letter to UNCAT

Letter to UNCAT from a Survivor of Lake Alice Hospital, New Zealand

I would like to write independently to the United Nations Committee Against Torture (UNCAT) as a victim of mistreatment, abuse and torture. This is concerning the New Zealand government and their response to my complaint and hundreds of others that were subjected to abuses as children in psychiatric and welfare institutions.

I write as a former patient at Lake Alice Hospital in the Child and Adolescent Unit, Marton, New Zealand during the 1970s.

I have two younger sisters and a brother and at the time my father left our family, and my mother couldn't handle me. I was put in Lake Alice when I was 12 and discharged at 16 years of age after five admissions. The first four were as an informal patient and the fifth was as a formal patient.

My nursing records show that I received painful Paraldehyde injections for such things as throwing apples. I also received electroshocks without anaesthetic for things like challenging a staff member, wetting the bed (ECT on the testicles x 8) and for running away. My file records show that I had 92 sessions of ECT. Also if your grades were not up to scratch you were marked in the red book and you also got ECT.

I have since made many statements about the events that I experienced while in Lake Alice.

In 2005 I complained to the correct statutory authority, the Medical Practitioners Board of Victoria, Australia, but have not been able to find out anything about my complaint which include being painfully electric shocked on my body parts by an ECT machine on a number of occasions. The investigation was called off when the psychiatrist decided on the eve of the hearing to resign. The Medical Board had obtained an independent medical opinion into the conduct of the psychiatrist who was in charge of the unit. A request to get a copy of this has been refused.

I am concerned that none of the former staff have been told that what they did was wrong. Some of them are still alive and been working in mental health with children and youth. There have been millions of dollars paid out to other former children and adolescent patients who were in Lake Alice like me. The New Zealand Medical Council and Nursing Council have not said anything that happened was wrong.

In 2003 I made a statement to the lawyer representing the Government who handled my claim which was against the Government. The lawyer was Dr David Collins, a Queens Counsel, who is now New Zealand's Solicitor General. I received an ex gratia payout and an apology where the Government said what happened to me was wrong.

I found out that the Government withheld 30 percent of my payout in “legal and administration” fees, even though they said that I would get a Crown funded lawyer to represent me. I got a private lawyer and won the case of the legal fees against the Government over this. The NZ Government tried to appeal that I won the case but then gave up the appeal. They then would not pay and it took a public push by the media before they handed over the money the courts said they owed.

This was estimated to be around $3 million that the NZ government withheld from the child-victims of Lake Alice I the second round of payouts.

I suffered ill treatment and torture as a child at Lake Alice at the hands of former mental health staff, psychiatrist and nurses. I have exhausted areas of complaint to achieve any of the staff being accountable. I feel this is important so that children won’t be wrongly diagnosed, given drugs, and electric shocked as punishment just because of any perceived behaviour problems like I was. It is not the children’s fault.

I am appealing to the United Nations Committee Against Torture. What happened to me was not treatment, it was punishment and torture. What the UNCAT has asked of the government:

> “The State party should take appropriate measures to ensure that allegations of cruel, inhuman or degrading treatment in the “historic cases” are investigated promptly and impartially, perpetrators duly prosecuted, and the victims accorded redress, including adequate compensation and rehabilitation.”

This hasn’t been done and is what we have been asking for, particularly that they are “investigated promptly and impartially, perpetrators duly prosecuted, and the victims accorded redress, including adequate compensation and rehabilitation.”

Paul Zentveld
6 November 2010

20 Akatea Rd
Glen Eden
Auckland
New Zealand.

Victim letter to UNCAT

To the United Nations,
I am writhing to you to express my disappointment with the police investigation into the abuse we were put threw while in Lake Alice , I don't know how the Police can say there is not enough evidence to charge anyone when they didn't contact me for my side of what happened , as when i complained to police 6mths after getting out of lake alice about how i was treated , i was told there is know way things like that would happen in NZ and did i know how serious it was to make up stories and as i was only 16 with no backup from parents dropped it as i felt threatened and was afraid of being locked up and abused again . as for the so called compensation paid out by the NZ Government after legal fees 50% of pay out we got about 6mths wages for 35 years of pain and suffering to date i am still affected by how i was treated

in Lake Alice , getting justice will help somewhat but wont fix everything . I have lost jobs as have times of deep depression sometimes lasting 18mths caused by what i went threw in Lake Alice. it has also cost me relationships our Government seems to think a few Dollars will make everything better , no help was offered to help with the emotional problems caused,
Its very hard to do some things as i have a strong distrust of Doctors/ Police/Employers/anyone in authority I carn't even go to parent teacher interviews so is affecting my children as well someone somewhere has to make this right.
Yours Sincerely
Malcolm Richards