***INTRODUCTORY CHAPTER***

***Revised, 20 May 2023***

***Synopsis***

*This is the introduction to a series of essays – perhaps chapters for a publishable book – deriving from my many years of concern about shortcomings of the New Zealand mental health system. My concerns came to a head in the context of a very large undertaking authorized five years ago by the newly-elected New Zealand government under Prime Minister Jacinda Ardern – the Royal Commission on Abuse in Care. It was a courageous decision in my view. However, my concerns predated this, and include matters never to be addressed by that Commission. When first proposed, the Royal Commission referred only to care in state institutions, but it soon expanded to include care in religious institutions. My focus here is just on care in state institutions, particularly two former mental hospitals.*

*Most of this first chapter describes my own story, to show that I have a unique perspective from which to comment on the above matters. That account has a special focus on hard events in the last ten years for which I was a witness. My objective is to show how, as a relatively innocuous ‘retired’ academic, I was forced, in my 70s, to become involved in the complex and at times devious world of mental health politics. This led me to use my research skills in a series of investigations which became increasingly focused and scientific. From the start of these investigations my emphasis has been not mainly on details of the abuse (especially in the 1970s, and well documented by the many courageous witnesses to the Commission). Rather I focus on where ultimate responsibility lay for the fact that this occurred and was covered up so effectively and for so long. Testimony of witnesses to the Commission seems to have placed little emphasis on this crucial question. In this regard, it seems likely that the Royal Commission’s final report, expected to be released in June 2023, may fail to cover important evidence and/or background material.*

*My concerns about such omissions were heightened by a disappointing event just over two weeks ago. In January 2022, I took part in an encouraging three-hour recorded discussion with skilled legal staff working for the Commission. I was left with a firm impression that this would lead to my signing a witness statement, and then appearing at one of the last of the Commission’s public hearings to present evidence from my investigations. However, on 8 November, there was an announcement from the Commission, in celebratory tone, that its last public hearings had by then been held. Obviously I was not included, and I wrote immediately to express my disappointment and sense that I had been seriously misled. It is of great concern to me that, despite the vast expense of this Royal Commission, there seems to be a reluctance on its part to explore the vital question on which I focus, namely the locus of ultimate responsibility.*

*My primary objective here is therefore to make an important body of evidence available to the public; but there is a secondary objective. Inevitably there are gaps in the story I tell. By going public in this way, I hope that others, readers with different experiences to share, who know other parts of this story, can help fill in some of those gaps. I believe it is a compelling story. My friends tell me that I have an important duty and responsibility to tell this story.*

*In this initial essay I explain first my dark, somewhat enigmatic overall title to the forthcoming sequence of chapters. Then I will give an account of my own story, including events which led me into the fractious world of mental health politics; and, at the end, I summarize the structure and objectives of chapters to follow.*

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***My Title*:**

This derives from Shakespeare, from what is probably his darkest play ‘*Macbeth*’. The full quotation is about connivance (roughly equivalent to Orwell’s ‘*Double think’*), that is ‘turning a blind eye’ to something we know about but, paradoxically, do not want to know about:

*The Eye Wink at the Hand; yet let that be*

*Which the Eye Fears, when it is done, to see.*

In other words, we turn a blind eye to what we are about to do; yet we still do it; and when it is done, we are horror-struck, and blinded even more by - and fearful to look at - what we have done. The theme of connivance runs through and through the essays which follow. More than that: Shakespeare’s *Macbeth* portrays with formidable insight how heinous state crimes are perpetrated, in ways which propel further crimes. His tragedy is thus timeless. Four hundred years later, it is singularly appropriate to my theme. So, I add the phrase ‘*a modern tragedy’*, and will head each chapter with a quotation from Shakespeare’s great tragedy,

***My Own Story*:**

I was born in the industrial city of Sheffield, in the north of England in 1943, and did my schooling there. Even before I left secondary school I had become interested in the workings of the brain. In the 1960s, I was a medical student at Oxford University. Before starting the clinical part of medical training at a London teaching hospital, I had undertaken a year of experimental neuroscience research in Oxford, recording electrical signals from single nerve cells of brains of anaesthetized animals.

 I never completed the medical degree because I was overwhelmed by psychiatric problems. In November 1966, after various psychiatric consultations, I disappeared from that teaching hospital, returning home to recuperate and wait for prescribed antidepressant drugs to take effect. Within a fortnight I experienced a complete mental breakdown: You might call it ‘psychosis’ (a term, whose definition has expanded in unhelpful ways in recent years). More accurately it might be recognised as florid mania. I was admitted to the main mental hospital in Sheffield. Mental health services in Sheffield at the time were more than usually liberal and benign. The head of psychiatry in the University of Sheffield and foundation Chair, was one Erwin Stengel. Thirty years earlier he had been a refugee from Vienna at the time of Hitler’s Anschluss into Austria. In his time in Britain, amongst his other work, Stengel was to translate into English one of Sigmund Freud’s early books, and in 1961 successfully advocated for the decriminalization of suicidal acts.

I was not in that hospital long, but spent about six months as a day patient in a small psychiatric clinic in the western suburbs of Sheffield. It is a complex, yet fascinating story, which I have described elsewhere. I did experience electroconvulsive therapy there – four times, modified by use of injected barbiturate anaesthetic, as was standard practice. Compared with the overall melt-down of my life at that time, it was no big deal. The next two or three years were bleak, with no hopes for the future. I had simple employment; but, as I now know, my low morale and sense of drained energy, were mainly due to sedative effects of medicines I was prescribed. However, in 1969 I obtained a research assistant job in Glasgow University. By 1973, I had a doctorate from there on a different area of neuroscience, and, remarkably, by now, had research experience in both pharmacology and electrophysiology related to brain function. I was not skilled in the experimental side, but hoped to make a career working on the theory of brain function, based on meticulous scholarship of what was already published and in academic libraries, followed by imaginative hypothesis formulation, and then – back in the library – testing my hypotheses by searching out further research studies, or by making inferences for further testable predictions.

After a life-time’s work in that area, I now understand my psychiatric problems far better than I (or anyone else) did at that time. Certainly, as a young adult, I had a tendency to ‘depression’ (a term whose definition has become ever more vague), and which, at the time was quite disabling. Today this has not been a problem for many years. However, it was linked with sensory difficulties which have been with me throughout my life. These include sensitivity to noisy environments and overstimulation of all sorts; some difficulty in recognising people by their faces; yet, combined with this, an auditory sense which is remarkable for its acuity. Sometimes when I fail to recognise an acquaintance by their face, I know who they are the instant I hear their voice. Music – especially musical composition - was important to me from teenage years, and still is; but to give an idea of how sensory problems disabled me, I recount the following interesting episode: At secondary school, I liked singing in the school choir. At university, I no longer enjoyed it. Only much later did I grasp why this was so. At university, the voices of my fellow choristers were now much louder, and I simply could not hear my own voice, and was therefore singing quite out of tune. Much later, I recovered my joy in singing; but now, for better or worse, I only sing solo.

In the 1970s I experienced one further episode of florid psychosis, and a few ‘near misses’ as I tried to wean myself off psychoactive medicines. At one stage this led to my receiving the diagnosis of ‘schizophrenia’, an important event for me. Much later, I came to understand better how psychoactive drugs work. It is now clear to me that those psychotic episodes did not reflect any underlying illness, but were serious side effects of medicines I had been prescribed. Such complications, although uncommon, are now recognised as possible. They were not understood then, but - to some extent – are now. Today, at age 79, I am blossoming. I take no medication, I am fit and active, with a confidence I never had when younger.

By the mid-1970s, I was in an unusual situation: Before I crashed out of medical training, I had seen hospital medicine as a medical student; had first-hand experience of psychiatry as a patient; and had growing understanding of brain science in more than one specialist area. As a researcher working on theories of normal brain function, I was keen to use my understanding to throw light on major mental disorders. However, in attempts to find employment in Britain, I found that the notion that I could combine these perspectives as a serious researcher was beyond the grasp of academic institutions. In this context I emigrated to New Zealand.

I arrived at Easter 1977 to a position in the Department of Anatomy, Otago University Medical School, a position I held until the start of the year 2000. Emigration is often difficult for new arrivals, and so it was for me. Nonetheless, I have never regretted the decision. More recently, as this series of essays shows, I have become aware of the dark and hidden side of New Zealand history. Such dark corners exist in the history of most countries, if truth be told. Nonetheless, I have now spent more than half my life in Aotearoa New Zealand, and am a proud citizen of the remarkable country which is my adopted home.

In Otago things went well – mainly – for the first fifteen years. My research output as a brain theoretician was based partly on considering age-old philosophical debates, combined with in-depth study of what was already known about brain structure and function, published and in academic libraries, but never stitched together in a way that made sense. My work was coming to be noticed. I was also getting to the stage where my brain theory helped to suggest plausible accounts of some mental disorders, or their presenting ‘symptoms’, and the mechanisms by which psychoactive medicines work. The best of this work, generally based on research studies in animals, addressed fundamental topics, but, at that time, was not intended to offer anything to psychiatry. Thirty years later, as my understanding has increased, I believe it does. In particular I can now see that some of that fundamental work helps answer a conundrum which had been on my mind even from school days: How does that remarkable organ inside our skull construct for each of the sense of being a person? If such a question can be given an acceptable scientific answer, it must surely also be fundamental for the discipline of psychiatry. I now have a clear idea of a major work, which I might yet be able to complete – a scientific theory of human personhood[[1]](#footnote-1). However, there is so much going on in my life at present that this may not be possible as an isolated researcher.

***‘Schizophrenia’: Origin of the Concept; its Decline and Fall.***

In the early 1970s, in Britain, a pioneering organization - the National Schizophrenia Fellowship (NSF) - was formed by parents (and others) whose offspring had received the scary diagnosis of ‘schizophrenia’. In the two years before I emigrated I become a member of NSF. Six months after arrival in New Zealand, as I started to settle in my new environment, I wrote a n account of the circumstances of my emigration, which was published in the NSF Newsletter.

Soon after I arrived in New Zealand, a similar organization was started by three brave advocates from Christchurch. By November of that year, a local branch was formed in Dunedin, home city for Otago University, and I was at its inaugural meeting. My association with that organization was an important part of my activities outside work in years after arrival in Otago. To explain this more fully, I must digress, to give an account of the history of that ‘diagnosis’ (a very problematic diagnosis, as I now see it).

The term ‘schizophrenia’ was coined around 1910 by the Swiss psychiatrist Eugen Bleuler. Its predecessor was a latinised term ‘Dementia praecox’ – early dementia - which came from the German psychiatrist Emil Kraepelin. This was the time when the form of dementia now called Alzheimer’s disease, had been defined, supposedly on the basis of brain pathology, but perhaps on shaky grounds. Kraepelin envisaged that he had defined an equivalent disorder of early onset (and, I now say, *definitely* on shaky grounds). In later years, Kraepelin’s term, and later schizophrenia, were incorporated into the lexicon of psychiatry in the English-speaking world. However, since both terms originated in the German medical literature, and any evidence which enabled Kraepelin to formulate his original concept was inaccessible, the schizophrenia concept and the symptoms by which it was supposed to be recognised were adopted mainly on the basis of unassailable authority rather than evidence. Despite its ill-defined nature, the term came into common use (and misuse). At that time, serious psychiatric diagnoses had very negative connotations; and, as for schizophrenia, it was the end of the road[[2]](#footnote-2).

Fast forwards to the 1950s, and another throw of the dice. A sad fact about us human beings is that, very often, when we are aware of serious tragedy or disturbing realities beyond our comprehension, we try to find some person or human agency upon whom to cast blame. Sad? Yes, because wiser council recommends us to admit ‘I do not understand’, and then strive towards understanding. This said, by the 1950s, the idea spread that ‘schizophrenia’ whatever it might be, was a product of incorrect methods of child rearing. So, parents - especially mothers – were blamed for their offspring’s difficulties - the ‘schizophrenogenic mother’ hypothesis.

For myself, as I started to come to terms with the events in my life in the late 1960s, I always saw this ‘hypothesis’ as ill-founded and cruel. My own parents, of working class background were nonetheless highly educated, and gave me a robust example of how to stay strong on principles, despite the turmoil of the times in which they lived. I owe them an immense debt of gratitude. However, when it came to the secretive world of psychiatry, they were right out of their depth, and, as I learned at the end of my mother’s life, frightened. All this is the explanation for why – unlike most of today’s service user advocates, I wanted to make an alliance with groups such as NSF, or its equivalent in New Zealand.

In later chapters, I will write more about my experiences with Schizophrenia Fellowship in early years in Otago. All I need say now is the bitter memories I gained of unquenchable anger of the aggrieved parents I met in that group, regarding the way the local mental health service treated their sons or daughters. I never learned any detail of objectionable treatment, but I was certainly made aware of personnel in the local mental health system, towards whom those parents had the most visceral antipathy. Those experiences were not easily forgotten.

***Psychoactive Medicines*:**

During my research, I became something of an expert on the mechanisms by which antipsychotic drugs work. For instance, in the early 2000s, I was asked to contribute a piece on the topic for an encyclopedia, published by the German medical publisher Springer Verlag. I was also probably the first to write a detailed review on the relationships between dose and response for antipsychotic drugs, a seemingly simple question, but actually very difficult: It is linked to other questions: What is the optimal dose of these medications for alleviating psychotic states? How much does it vary from one patient to another? . . .and how, in practice, can the dose be adjusted to individual sensitivity.

The story of how I got away from the antipsychotic drugs I was prescribed is interesting and reveals my expertise. After the initial breakdown – which I now attribute to antidepressant drugs - the context of subsequent recurrence of mania or incipient mania was invariably when I tried to withdraw the medication I had been prescribed. For many years I attributed this to recurrence of some sort of disorder. It never occurred to me that it was a withdrawal effect from medications. Indeed, for most antipsychotic drugs, sudden withdrawal psychosis does not occur. If recurrence of psychotic symptoms does occur, it is in an unpredictable probabilistic event, sometime in the months after withdrawal. However, for one medication – clozapine, this is not the case. This is a rather special medication in that it may be effective treatment when other antipsychotic medications have proved to be ineffective. It has therefore helped many patients. However, when this medication is suddenly terminated a withdrawal psychosis may appear very soon, often more intense than anything experienced hitherto.

The actions of most drugs and medicines are determined by what are called ‘receptors’, molecular keys which open the door to the drug’s actions. Most drugs act either by blocking the relevant receptor and attenuating its actions, or by enhancing or mimicking its actions. If a receptor is blocked for any length of time (a few weeks), the receptors increase in number. If they are continuously activated for a few weeks their number falls. Both are natural compensatory responses. The medication I took in tiny doses for over 40 years was thioridazine (‘Melleril’). As I studied the pharmacological properties of different medicines, I noticed that clozapine was quite different from most antipsychotic drugs, but similar in some respects to thioridazine. This insight led to a theory which was in due course published. I suggested that most antipsychotic drugs produce their effects in rather indirect ways, which means that the crucial receptors do not undergo much compensatory change. Clozapine, I surmised, acted much closer to the ultimate target of antipsychotic effect, so that compensatory receptor change would occur; and then, on terminating the medicine, a rapid rebound psychosis would follow, due to over-sensitive receptors. I also suggested that thioridazine was like clozapine, sharing its beneficial properties, as well as its hazards – and, yes, a search through the more obscure research papers, did reveal reports of rebound psychosis on terminating this drug, as I experienced, and as also found for clozapine.

In the early 2000s, my GP phoned me to say that thioridazine was no longer being manufactured. The next few months were tricky; but by now, I knew enough about the properties of alternative medicines so that I could choose ones to achieve a safe transition.

***Leaving University Employment: My Big Book on Schizophrenia*:**

 From about 1992, university administration was changing, as it did in many other countries. These institutions were now supposed not only to be ‘business-like’ – obviously necessary - but in fact to be businesses, with financial accounting taking precedence over what had hitherto been core objectives - teaching and research. As a library-based theoretician, I was not likely to draw large research grants into the university (which took a large top-slice for its own administration), and I was not interested in wasting my time on fruitless attempts to please the administration. So, I found myself overloaded with a seemingly endless rigmarole of routine teaching. My biggest research ambitions were far from completion and I was becoming ill with overwork. The focal point for those ambitions was a large monograph on the theory of that problematic disorder, schizophrenia.

Midway through 1999, I consulted my financial adviser, and asked ‘Can I afford to resign? Answer – ‘Yes, if you are prepared to be frugal’. Well, I’ve never been anything else, so I took my decision. From the start of 2000, I was off the payroll, to become what I called myself henceforth - a free-lance researcher. ‘Free-lancers’ were originally mercenary soldiers, paid for their services. I was not; but fortunately in the next nine years I had a year very well paid in Germany, and 11 months, moderately-well paid, in Montreal, Canada. In 2008, I completed the work which had been exercising me for many years, on the theory of schizophrenia.

The sequel to this is again very interesting. I always had nagging doubts about the validity of the schizophrenia concept, but it was hard to pinpoint the reason for my doubts. A pioneer in neurology, as he is known in the English speaking world, was the German clinician Carl Wernicke, a contemporary of Emil Kraepelin. He built that reputation in the 1870s as a newly qualified physician; but he spent the last twenty years of his life working in a psychiatric institution in Breslau, then part of the German empire (today ‘Wroclaw’ in western Poland). In the 1890s, as I knew from visits to Germany, Wernicke published a series of lectures to trainee psychiatrists, but they had never been available in English translation. Around 2012, I was in collaboration with a very good linguist – the late John Dennison, also an anatomist – to translate and edit Wernicke’s lectures. As I absorbed Wernicke’s ideas, I realised I was one of very few English speakers able to read the thoughts of a very fine scientist, who used all his ingenuity and intelligence to understand the many patients in his institution, all of whom he knew so well. He was generally quite generous to his professional rivals, with one exception – Emil Kraepelin, for whom he had nothing but scorn. He had no time at all for Kraepelin’s concept of Dementia praecox. Sadly, in 1905, Wernicke died tragically young, at age 57, in a bicycling accident. Kraepelin outlived him by 20 years with the result that it was the legacy of Kraepelin rather than that of Wernicke which has dominated psychiatry for much of the last century.

This work opened my eyes to the history of those times. My doubts about the schizophrenia concept now crystalised in a way which was not possible just from research literature (which was endlessly self-referential, and never explored concept validity in depth). The result now is that I no longer use the term ‘schizophrenia’ in a scientific sense. There is still a lot of good scientific reasoning in my big book, about unusual experiences, symptoms and other ways in which serious mental disorders manifest themselves, but that reasoning should be regrouped around concepts quite different from the outdated, always-too-vague concept of schizophrenia.

***My Present Approach to the Discipline of Psychiatry*:**

At present, of course, my views on psychiatry and mental disorder are an incomplete story – always developing. However, I summarize the position I have reached with a few simple statements, which may bring calm to the angry polemics swirling around these topics. These statements, I should say, are about psychiatry as a discipline. The standing of the professional bodies for psychiatrists is a separate matter, which I address in a later chapter.

Since the days of Sigmund Freud, psychiatry has been split between those who think in terms of biomedical disorders or neurobiology, and those who adopt some version of the dynamic tradition, which Freud developed (but was much older than him). This cleavage is related to another split which emerged at the same time – between psychiatry and neurology. Early in Freud’s life the two were not separate. Both Freud and Wernicke started their careers as a ‘neuropsychiatrists’, a rare breed nowadays. Both splits may have occurred because it was proving too difficult to hold the different factions together in a single discipline. Better to have uneasy rivalry between different factions, each of which had only partial insight, than to tackle the hard task of integration – or so it seems.

For myself, I never saw the two traditions in psychiatry as incompatible, nor that neurology of higher nervous functions need be separate from psychiatry. To bring these together in a coherent way – to reunite the by-now disparate traditions – is an obviously attractive approach to a forward-looking psychiatric profession. However, to do so, both in broad perspective and in detail, is a task of immense difficulty, underestimated by many protagonists of modern-day neuropsychiatry. As a result, there have been those who advocate this approach, without the depth to do it properly. Indeed, I regard some of those advocates, who use the catch-all term ‘neuropsychiatry’, while skating over some of the intrinsic difficulties with loose reasoning, as false prophets and dangerous. They use the seeming attractiveness of the approach, to promote a quite different undeclared agenda. Later chapters give substance to this warning.

Part of the difficulty in making psychiatry a discipline true to historic traditions in other areas of medicine, is that, in most societies, there are other forces which want to introduce their own agendas into the discipline – political, religious, philosophical - but also, as we see in later chapters, military and intelligence capabilities. Moreover, it should not be forgotten that psychiatry as a quasi-medical discipline followed the days when asylums or private madhouses had no such pretentions. As a result, even when psychiatry started transforming itself (and mental institutions came to be called hospitals), the discipline was still largely an administrative rather than a clinical specialty. We still see this: In 1980, the haphazard, undisciplined process of diagnosis which had prevailed hitherto in US psychiatry became ‘regularized’ in the American Psychiatric Association’s ‘DSM-III’ (Diagnostic and Statistical Manual, Third Edition); but this weighty document did not provide diagnoses with either scientific or firm clinical validity. Mainly its diagnostic definitions were intended to help the administrative side of mental health care, partly regarding finance, and partly to avoid the charge that psychiatrists’, power to detain people in mental hospitals, was being used for purposes that were nothing to do with health care. Overall, psychiatry is easy prey, easily co-opted to become subservient to these other agendas. In this confused scene, many critics of psychiatry have wanted to do away with the discipline altogether: They are ‘antipsychiatry’ *per se.* That is not my stance. I would like to see profound reform of the conceptual basis of the discipline, but I also admit my uncertainty over whether this is possible without the discipline being comprehensively dismantled.

As for psychoactive medicines – yes – they do have a role in psychiatry, but few practitioners have adequate skill and experience to prescribe the medicines to best advantage for their patients. Even further from today’s reality, are prescribing habits based on proper appreciation of the underlying theory of how those medicines achieve their effects. Antipsychotic drugs are generally prescribed in excessive doses, and inflexibly, with no understanding of the principles which should guide their use. This reflects the unsupportable excesses of power of the pharmaceutical industry.

To achieve the profound reform which I believe is needed, theoreticians in psychiatry need understanding of facets of brain science far beyond the simplistic notions of neurochemistry, transmitters, and the drugs which influence them, which topics form most of the scientific basis for the multinational pharmaceutical industries. Specifically, the reformed discipline must be based on a proper scientific theory of human ‘personhood’ – how our brains construct for each of us that sense of being a person, and then continually reconstruct that ever-evolving sense, while ever we are alive. This must be the backbone of a properly scientific psychiatry which can reunite dynamic and biomedical sides of psychiatry. As elsewhere medicine, understanding the ‘normal situation’ will then be a condition upon which deviations from normality are also understood. In the 1890s this was the unfulfilled ambition of neuropsychiatrist Carl Wernicke, who, more than any other, now inspires me. I can now see how the neurobiological and psychodynamic traditions within psychiatry can be reunited, based on fundamental brain theory. I think I know how it this can be done, but it is such a huge task that, without help of an energetic collaborator, I cannot see that this will ever be done.

***Transition to Political Activity in the Mental Health Field*:**

For most of the preceding fifty years, in one way or another, I had been on the fringes of the discipline of psychiatry, observing its transitions, failures, and occasional successes and the behaviour of psychiatrists in all their diversity; but I was never part of their system, never held responsibility for the undoubtedly difficult decisions which were their daily challenges; never bound by their disciplines; and never involved in the intricacies of mental health politics. I was never a political animal. I had too many other pressing concerns to be so involved. In 2009, at age of 66, I was in a reasonably secure, if not wealthy financial position and moved from Otago to Masterton, in the North Island, and within easy reach of the capital, Wellington..

In 2012 I helped run a very successful one-day work-shop in Wellington on psychiatric diagnosis. If this was political, it was so only in a low-key manner. However, one development is relevant here. We were very fortunate in being able to bring, as a keynote speaker. Professor Alan Frances, of Duke University, North Carolina. At the time he was visiting Australia, so it was not too expensive to bring him across the Tasman to join our workshop. It was Alan Frances who headed all the committees of the American Psychiatric Association who put together in the early 1990s, the next edition of DSM – DSM-IV. By then time of our workshop, another edition, DSM-V, was about to be launched, and, by then, Alan Frances was the most potent public opponent of what was emerging. His performance at the workshop was superb. The audience of about 70 people was very diverse; and after his talk, walking up and down the central isle he fielded a long set of very diverse questions, always straight to the point, courteous, and well phrased to match the perspective of the questioner. Only once in a long session, did I detect any comment raised in anger. At the end of the workshop, I was struck by a warning from him – of how a health screening program for pre-school children, unrolling at the time in New Zealand - and soon in Australia - included a section attempting to identify supposed psychiatric problems in pre-schoolers. In months after that, I worked hard to find more about this topic, and I came to understand the cause of Professor Frances’s concerns. The mental health screening instrument – the Strengths & Difficulties Questionnaire (SDQ) -was seriously flawed methodologically. Furthermore, in origin, a major objective guiding its development overseas was to find ways to predict in pre-schoolers teenage rebelliousness, and later, in adults, criminal tendencies. This topic connects in a direct way to some of the atrocities discussed in chapters1-4 of this sequences, and the analysis in Chapter 5. It is certainly political.

At this point, my life took on an increasingly political direction, quietly so, because that is my style. However, I must have had an inkling that this might happen, because, when I relocated, I never let my phone number go in the directory. Long before the Royal Commission on Abuse in Care was established in 2017, two experiences led me in a political direction.

In 2009, I was shoulder-tapped to be a community representative on committees of the bi-national Royal Australian and New Zealand College of Psychiatry (RANZCP). So, from time to time, I was flown over to committee meetings, usually in Melbourne, and to their annual congresses in a variety of centres spread over both countries. I was of course aware of widespread rumours about dark events in New Zealand’s mental hospitals, and my encounters with those aggrieved families in the Schizophrenia Fellowship in my early days in Otago gave me reason to take those rumours as indicators of dark corners, which needed a bit of sunlight. Shortly after this I became aware of interviews recorded on Radio New Zealand with two persons who had been student nurses at Porirua hospital, north of Wellington, in the late 1960s. I obtained copies and listened to them carefully. I started to ask questions within RANZCP, including questions about the history of that college.

Soon after joining those committees, at the college’s annual congress (on this occasion at Hobart, Tasmania) I ran a symposium under the title: ‘*Anger resolution in Psychiatry: Laying the Ghosts of the Asylum Era’*. My presentation which started off the event was at once deliberately emotional, and coolly analytic; but it also challenged the college to reconsider its own history and origins as a Royal College. My account of this event has been made available.

I am not a good committee person. To rephrase this, the dynamics of committees often do not lead to very fruitful discussion or decision making, because they are always dominated by the persons who get their words in first, howsoever trite or stupid they may be. There was however, one occasion where I may have had significant impact. The issue was whether psychopharmaceutical medicines should be advertised on television. At present, for medicines generally, only two countries permit such advertising, USA, and New Zealand; but for medicines in psychiatry, the issue is sharper than for general medicine. When I spoke on the issue, I was more than usually intense. I mentioned the intriguing historical fact, that growth of the American public relations industry after the first World War, was led by one Edward Bernays, American cousin of Sigmund Freud. Bernays, more than anyone else, introduced a style of marketing which aimed not at anything superficial about a product, but, by subtle association, aimed to influence underlying motives, which might then persuade unwitting consumers to buy whatever product it was needed to sell. In brief, he was adapting Freud’s ideas for marketing. In committee I asked: ‘*Do we really want that sort of ploy to be used to persuade people to buy pharmaceutical products, persons who are themselves already struggling with their sense of personal wholeness?’* I never heard how much my words influenced political decisions; but TV advertising of psychopharmaceutical medicines was never introduced.

Five years later, I was about to move away from RANZCP committees. By this time my investigations into history were taking shape in a more serious way. I knew a lot about the history of psychiatry in the twentieth century, profoundly influenced of course by two world wars, and the Cold War. I could not pinpoint what dark secrets might be hidden in the history of mental health care in New Zealand, but I knew a lot of the historical context world-wide. There had been no response to the challenge I had put to the college in my symposium five years earlier. It was clear to me that there *were* dark chapters which some of the older college members must know about, but had apparently by now, conveniently ‘forgotten;’ At one of the last congresses I attended, I was quite ill, due to a dietary problem. which had not yet been diagnosed (but now, thankfully, completely resolved). Nevertheless, I managed to deliver a short twenty-minute paper, in which I reminded the audience of my symposium five years earlier. I told the audience that no-one had been willing to approach me to discuss the sources of my disquiet about unacknowledged parts of the college’s history; and I ended with four emphatic words ‘*This is too slow’*. Later, in a private conversation with one of the psychiatrists on our ‘Community Collaboration Committee’ I put to him the sharp question: *‘How fast could this college move, if there were an existential threat?’* He was quite perplexed. It was beyond his grasp that hidden events in the past might pose an existential threat to the college. He was a person I would trust; but being much younger than me, there was no way he could connect with the times on which my attention focused.

At the congress, my last committee meeting was interesting and, in the end, rather dramatic. The whole session was recorded, which was unusual. I assume someone knew that significant things might be said - perhaps by me. I explained why I was leaving the committee, but I struggled for words, because I was quite unwell. I did say that I thought the college was ‘*in early stages of falling apart; but it might struggle on with varying degrees of dysfunction’*. Right at the end, another community representative, a sweet eighty-year-old from Queensland bowed out by reciting a beautiful poem. At that point I had a moment of inspiration, and I too recited a poem, sixteen lines of defiant independence, crystalline in their symmetry and precision, under the title *‘Invictus’*. They were penned by William Ernest Hensley in 1875, as he recovered from major surgery. The last four lines read:

*It matters not how straight the gate,*

*How charged with punishments the scroll*

*I am the captain of my fate*

*I am the master of my soul*

Then, in another fit of inspiration. I stood up and sang to the committee a well-known song from that genius pianist, singer, and entertainer from 1920s Harlem, Thomas ‘Fats’ Waller:

*I’m going to sit right down and write myself a letter, and make believe it came from you (etc.)*

Perhaps the symbolism of my choice of that song escaped committee members. I was hoping that someone would realize that I had real concerns about that college, and that after I left the committees, someone would write me a letter to find out what was the basis of those concerns; I never did receive such a letter. Not only did college members never want to discover what was troubling me, neither did most of the other seven community representatives on the committee follow up my bitter adieu to the committee. There was one exception, who I mention in a later chapter. In recollection, I regard the manner of my exit from those committees as one of my finer moments.

***Death of a Young Man I Tried to Help. Flawed Investigations and Inquest*:**

The second, and much sharper set of experiences which led me into mental health politics started midway through the year 2013. I was approached by a lady I had got to know in my region, who had told me about the mental health problems of her son. Early in June, she phoned me, asking if I could meet with her son to help him. Generally I refuse such requests, because I am a scientist, not any sort of clinician. However, half-an-hour later her son called me, and asked to meet. I could not refuse this, but made it clear this would be on the basis of possible friendship – a friend in need, so to speak - not any sort of professional relationship. When I met him, I was impressed by his quick mind and sharp intelligence, but also by the fact that his ‘world view’ was extremely idiosyncratic, and far from my own. Later I realised that this young man, who I met at age 32, had already been struggling for 20 years with growing mental health issues and the local mental health services. His saga started before the age of 10, with sexual abuse at a boarding school. In the two years that I knew him, I did my best to help him, witnessing with increasing concern, how he was treated by mental health services and in-patient wards, in two District Health Boards. On one occasion I had a face-to-face conversation with the Chief Executive of one of those DHBs. In the course of this, it seemed that he was asking me to take his side against the feisty, embattled mother of this young man. Perhaps he was trying to recruit me as an ally; but I knew where my responsibility lay. I was relatively powerless, so part of that responsibility was to collect evidence.

In April 2015 this young man killed himself, while an in-patient in the acute mental health ward of a major public hospital, part of the other DHB. I was there at his funeral. A few days later, the Chief Executive of that DHB circulated to more than 3000 employees of the DHB her version of the events leading to this young man’s suicide, with numerous factual errors and derogatory remarks about the grieving mother. Later, I learned that, although this letter went out under her signature, it’s exact wording had been worked out collaboratively, in haste by middle management from both DHBs, who feared a newspaper exposé about the death the next morning; but that article never appeared.

After this, over the next four years, there was a succession of ‘investigations’. During that period I worked assiduously with the deceased’s mother. She had a lifetime of experience in nursing in several countries, and in its auditing. She had a style very different from my own, and was by no means an easy push-over. Together we were a force to contend with.

The first of these investigations was conducted by the DHB itself. I now know that important lines of evidence were deliberately excluded from consideration by the investigating panel. The Responsible Clinician at the time of death had conveniently moved to Australia shortly after the death, and was never interviewed. The panel’s bland report was released seven months after the death. When the mother of the deceased went to the hospital where her son died, to collect her copy of the report, there seemed to be unnecessary delays. An altercation ensued, the security guard was called, and this slightly built lady sustained injuries as she was thrown out of the hospital foyer (as substantiated shortly after in a medical report). Calls for an enquiry led nowhere, and we never learned the identity of the security guard.

The Privacy Commission investigated the ‘All Staff Email’, sent out by the CEO a few days after this young man’s death. It found that the CEO breached several items in the Privacy Code. She was censured by the Board, but remained in her position until her five-year term expired, and then relocated to a similar position in an Australian city. The administrators in the two DHBs who worded that letter were never identified (although I now know who they were). The Privacy Commission finalized its involvement by giving the aggrieved mother a certificate to refer the matter to the Human Rights Tribunal, but offered no help in progressing the matter to this agency. In due course the matter reached the Human Rights Tribunal, which met to consider the matter early in 2020. In the week before this hearing, there were intense negotiations, and eventually it was agreed that a settlement would be reached. In the next few days exact terms of settlement were negotiated. (a) A financial settlement whose details were secret (of little more than symbolic significance); (b) A public apology by the DHB; (c) No restrictions on what the aggrieved mother could say to the media. (The DHB attempted to have a ‘gagging clause’ inserted; but were not successful.) Neither the CEO not the head of the mental health team ever appeared for cross-questioning. Senior figures who contributed to framing the offending email were never called as witnesses.

Two years after the young man’s death, there were vigorous attempts by a barrister trained in one of the world’s best law schools, working *pro bono,* to bring an action against the DHB in terms of the New Zealand Bill of Rights – specifically the most fundamental of all Human Rights, the Right to Life. This was about to go to the High Court in Wellington, but his mother was prevailed upon first to go for a session of mediation. The New Zealand judge who presided over the session flew in from one of the Pacific Islands. Pressure for her to settle was immense. She did force top dollar out of the DHB - who in essence admitted their culpability. The sum was paid, of course by the DHBs insurance company; but this payment was in exchange for her agreeing to a meaningless gagging order. The matter never went to the High Court. Both she and her barrister were immensely stressed by the decision and how it had been reached[[3]](#footnote-3).

Then we come to the lead-up to the inquest. It is a curious fact, that in New Zealand, when a death occurs in questionable circumstances for a person in health care, for obscure reasons, the inquest cannot go ahead until a report on the case has been prepared by a body entitled Health and Disability Commission (HDC). There is, as far as I know, nothing equivalent for questionable deaths in other circumstances. A further curious fact is that there is no appeals process linked to reports coming from HDC[[4]](#footnote-4). The evidence to which I had access was slim to start with, but by mid-2017, I had more a complete set of clinical files. On this basis we submitted several documents to HDC, which became increasingly lengthy and detailed as the time progressed. At one stage, the deceased’s mother was called to an interview with HDC investigators. Despite vigorous protestation by both of us, she went to that interview without me accompanying her: I was specifically excluded.

In December 2017, the mother of the deceased, along with myself, met a coroner who, we anticipated, would conduct the inquest. We felt he was trustworthy, expected the inquest to occur within a few months, and that he would conduct it in a fair manner. Soon after, in the New Year, we received a draft of the HDC report, for our comments. There were many inadequacies in the report. In our response we criticized both of the DHBs involved, regarding matters not adequately addressed in the report, and we also criticised the HDC itself. The most serious allegation we made, from study of clinical records and other evidence, was that, even before the young man’s last admission to hospital, behind the scenes, there had been what I called ‘covert planning’ that at some stage he should be relocated to the regional rehabilitation and forensic unit. This was a medium secure facility, although he was not a forensic patient. This should have been discussed at an early stage with his mother. Any such move required informed consent, from him or from his close relatives, and due legal process should have been followed. Our evidence for such covert planning was circumstantial rather than direct documentation, but certainly raised serious questions which should have been followed up.

After sending back our response to HDC, several things happened. Very soon after, the HDC case manager quit his job and disappeared. I was never able to track down where he went. Then we learned that the coroner we had met before Christmas was to be replaced by another coroner. There was therefore a long delay before another draft report was prepared by HDC. It was only much later that we learned who the replacement coroner was to be, someone more senior in the ranks of coroners. He was not at all interested in face-to-face meeting with the deceased’s mother and myself. I have good reason to believe that when he was assigned to this case, the coronial service already knew our allegations on ‘covert planning’ of this young man’s future.

In September 2018 we received the draft of what was to be the HDC final report for our comments, and with hard work in the next few weeks we responded with a critique of 120 pages, longer and more detailed than the one sent earlier. In late November 2018, the HDC Final Report was released to selected recipients. It had no additions of substance which were in any way related to our 120-page response to the September draft. Contained in a final paragraph of the HDC final report, and in the covering letter, was the HDC’s intention to publicize their report on their website, ‘for educational purposes’ with names of the deceased’s mother and myself redacted. She objected to this, with my support. She wanted to contest in public, the findings of the report, without either of our names being redacted. So did I. We were not afraid to be answerable in public. In ensuing correspondence, we eventually convinced the Mental Health Commissioner that we meant exactly what we said; and once he was convinced of this, he decided on 31 January 2019, that the HDC report would never be published on their website. However, by then the report had been forwarded to key players at the inquest, as if beyond criticism, to be taken as the best possible version of the facts of the matter. Moreover, on the day that he took the decision not to publish, he wrote to the interim CEO of that DHB, to inform the latter of his decision, his rationale being to avoid further stress to the aggrieved mother. This was a deliberately false statement, as correspondence clearly shows. The Mental Health Commissioner seemed unwilling to defend his report in public against our criticism.

Prior to the inquest there were two preparatory teleconferences. Huge bodies of paper work were circulated shortly before the first of these with very little time for parties to absorb the detail. At that teleconference another very vigorous advocate was present, who had been in far closer contact with the deceased than had I, in his last months in hospital. The coroner asked the mother of the deceased what she thought were the main issues, and she referred the question to me. My reply included a reference to the evidence suggesting covert planning of the young man being relocated to the forensic and rehabilitation facility. The coroner then stated bluntly ‘That did not happen’, without reference to all the evidence we had presented, and which was available in pre-circulated documents, had other parties had time to read them. It seemed that the allegation was new to lawyers for the DHB, who would have had no time to study the volume of paper-work shared before the teleconference. Subsequently the coroner never permitted evidence we had presented to be examined in court. My repeated requests that certain administrators, who might have known about this, be called to testify under oath, were rejected out of hand, with no reasons given. A few days before the inquest began, the coroner issued a ruling that no evidence could be considered prior to the date of the deceased’s last admission to hospital. I objected vigorously, but to no effect. Although the ruling was not adhered to strictly in court proceedings, it effectively excluded from consideration evidence for covert planning we had so carefully put together.

The inquest itself was very unsatisfactory. Early in the proceedings, the lawyer for the DHB mentioned the HDC report, and the letter from the Mental Health Commissioner to the interim CEO of that DHB. From what we by then knew, that letter implied that the Mental Health Commissioner gave a false account to the interim CEO of the reason for non-publication of their report - that it was to protect the mother from further distress (quite false), rather than to protect HDC itself from our criticism. The letter was forwarded to the DHB counsel shortly before the inquest began, presumably by the CEO for the DHB, a new CEO, newly-appointed shortly before he inquest began, and unlikely to aware of all the complexities of the story. There seemed to be some deception going on here.

In inquests, I understand, it is usual practice for the first person or persons to testify to be those most directly involved, namely the relatives of the deceased. For some reason this did not occur in this case. Indeed the deceased’s mother was one of the last to bear witness, after a six month adjournment of proceedings. At one stage the advocate for the deceased questioned the ward manager about correspondence between himself the ward manager, and with higher levels in the DHB; the ward manager could not point to anything wrong with *individual* messages; only that there were *too many* of them. This makes no sense. At this point, the advocate held up his dossier of correspondence, for the court to see, and offered to release it as new evidence. The coroner then suggested to the ward manager that he release those messages. After those five days, the coroner made an unexpected statement in his minute that the behaviour of the deceased’s advocate might be called into question. This had not been mentioned at pre-inquest teleconferences. Far from it: The coroner initially seemed to doubt that the advocate had any role to play. During adjournment the irregularity of court proceedings was admitted; and because the advocate now had to find counsel for himself, and because of commitments of all the other lawyers, the short adjournment became a six month adjournment.

Early in that adjournment, I sent to all parties a Submission of Concern, about several issues, including the deceptive way in which the letter from the Mental Health Commissioner to the CEO of the DHB had been misused to suppress the mother’s call for public questioning of the HDC report. Soon after I also wrote to the coroner asking to play a larger part when the court reconvened. His response was to say that I was no longer an ‘interested party’ in this case; or to use legal lingo (I think), I had lost ‘locus standi’ in that court. I could no longer be an active participant. All very interesting!

The long adjournment gave me time to do what I do best, meticulous scrutiny of all transcripts which were by then available. In November, I had reached the conclusion that the inquest was an expensive charade, in which potentially incriminating evidence was being systematically excluding from consideration by the court. So, I resigned from active participation in the inquest, although I still attended resumed hearings after the adjournment. It was a very difficult decision, but on subsequent reflection, I believe a correct one.

I was still able to communicate with all parties to the inquest, and immediately after, I fired off a series of documents, including one with my recommendations arising from this case. In these documents, I usually excluded the coroner from the mailing list. However, by early December I fired off a longer document to the coroner and Chief Coroner (but not to the other parties to the inquest), calling on the coroner to recuse himself, on grounds of appearance of bias and loss of independence. Of course, he took no such action; but my actions did get reported very briefly in a major newspaper.

The court was due to resume in late February (2020), with the mother’s testimony as a major component. There was to be another teleconference in advance of this, but I was excluded from this, as a result of the coroner’s ruling that I was no longer an ‘interested party’. However, a few days before the inquest reconvened, I sent a copy of my document calling on the coroner to recuse himself, to all the other parties to the inquest. This, I seem to remember, was on a Friday, with the inquest due to resume on the following Tuesday. Over the weekend there may have been frenetic activity by lawyers for the two DHBs, because, by Monday, we heard from lawyers from one DHB, soon echoed by those from the other, and supported by the coroner, that large parts of the mother’s witness statement should not be read in open court. At a time when this legal manoeuvre was known, the deceased’s mother gave another interview with the reporter from the local paper, whose report, included this detail. It came out the very morning that the court resumed its hearings, before any of the lawyers had had a chance to read it.

At the resumed inquest I was supposed to play no part. However, when the finances of the deceased were mentioned, during a break, I told the Clerk of the Court, that I has copies of all his bank statements. My advice was readily accepted although I had no standing in the court.

Shortly after that the whole of the country went into an unprecedented severe lock-down, dues to the accelerating COVID pandemic. During that period I completed a synopsis of the whole sad saga, and started to circulate it, not publicly, but to carefully chosen, but important people in the legal and political spheres.

At the end of July 2020, the coroner released his report on the case – bland and non-committal. The mother of the deceased, who I now knew very well has an amazing sense of humour, which matches my own. She loved the monologues of a past generation written by Edgar Marriott, and recited in inimitable dead-pan style by Stanley Holloway. The best known of these is a monologue entitled ‘*Albert and the Lion’* . After the Lion, sadly, had eaten poor Albert in Blackpool Zoo, Mr and Mrs Ramsbottom took the matter to the police. Two closing stanzas of Edgar Marriott’s monologue are fitting commentary on this coroner’s report.

*Then off they went to the P’lice Station*

*In front of a Magistrate chap.*

*They told ‘im what happened to Albert,*

*And proved it by showing his cap.*

*The Magistrate gave his o-pinion
That no-one was really to blame.
He said that he hoped the Ramsbottoms
Would have further sons to their name.*

Subsequently, this coroner ran into serious trouble in another case. In 2016, there was a police shooting in Rotorua, in which Shargin Stephens was killed. The police submitted their report to the coronial service and this coroner was assigned responsibility. He said the police report was fairly straightforward, such that a full inquest was not needed. It was an odd decision. Perhaps the coroner had learned from the previous case I described, that things might get out of his control, if there were to be really open justice. However, in June 2021, Guyon Espiner, tenacious investigative reporter for Radio New Zealand (RNZ), had done his own investigation and published a report on the RNZ website which was substantially different from the police report. Two days later, the coroner imposed a blanket embargo on any further reporting on this case, blaming the Stephens family for leaking evidence to the media (an incorrect allegation). In August 2021, RNZ (on behalf of Guyon Espiner) took the Coronial Service as a whole to the High Court in Hamilton. The case was not heard until nearly a year had elapsed, early in June 2022. I was at that hearing. It was short, because essential decisions had already been taken: Two days earlier, the police had withdrawn opposition to publication. RNZ won the case; the police, the coroner, and the Coronial Service as a whole came out of it in a very bad light; and RNZ was now free to publish on its website previously-suppressed detail of the case. This is just one of several recent cases where media scrutiny has focused on severe inadequacies of our judicial system. I expect more to follow on all this.

Returning to the case of the young man who killed himself, further issues arise from my investigations. In the long delay before the inquest, I had been able to collect almost all of his clinical records. For some parts, I had copies in duplicate from different sources. In critical places there were redactions. There are official guidelines governing the rationale for redaction – basically to protect the identity of persons mentioned who have nothing to do with the matters at issue. With this as the rationale, redactions should be essentially the same, whoever makes a request for copies of the records. However, since I had duplicate copies, I could compare the redactions in the alternative version; and this was definitely not how the redactions had been made. It appeared that redactions were made to protect the DHB staff members most exposed in terms of criticism by those asked for copies of the records. This is not how redactions are supposed to be made.

In the course of investigations prior to and during the inquest, I had met a number of journalists at various levels of seniority, and raised my concerns. Generally, I found initial interest, but once they realised the level at which my concerns were focused – higher levels of DHB administration (or above) – they backed away, avoiding further coverage. One of those journalists covered the story in some detail, but focused on the personal story of the aggrieved mother, and the outrageous all-staff email, but stopping short of trying to identify who or which agencies bore ultimate responsibility.

I do not want to be too critical of journalists. News media world-wide are under great pressure, with revenue needed to support detailed investigative journalism in steep decline. In this situation, it is understandable that newspapers and other news media avoid involvement in cases where investigation will be long and complex. When the focus is on higher levels of administration, or on the judiciary itself, investigation is likely to be immensely complicated. I need not therefore accuse media people of being party to a multi-agency cover-up. Their energies were better spent in cases where the *prima facie* evidence issimple and direct, as it was in the case of the All-Staff Email, or the death of Shargin Stephens.

The account I have just given does not deal in detail with the evidence, because it is not my main point, but just an introduction to the much darker story to unfold in later chapters. However I remind journalist who might read this, that I still have all the evidence I have collected, analysed and classified; and I might be willing to share it with journalists who can convince me of their integrity, for them to follow up on what I have written. Journalists who are now investigating shortcomings in our judicial system complain about difficulty in accessing transcripts of court proceedings. In the case I have just described, I do still retain that detail. It might therefore be a case to which serious investigative journalists might like to pay attention. In my main story, unfolding in later chapters, I *will* present evidence in more detail.

Do I fear litigation by releasing this series of chapters? Hardly so. Throughout this unhappy story, there was never an attempt to deploy any reasoned defence of the DHBs, HDC or the coronial process from our carefully collected and presented evidence and criticisms. The only defence they were able to mount, with varying degrees of brutality, was to close off avenues by which we could present possibly incriminating evidence in public. It seemed to be an exercise of brute power, disregarding the supposed detached unbiased and rational objectivity which legal and ‘open’ judicial processes require and claim to be their guide. What those agencies appeared to fear above all else was public scrutiny. This implies a deep sense of insecurity. At some level leading figures must know that their decisions could not withstand free speech, free debate, and full fearless analysis of evidence.

For me, by now, culpability of front-line clinicians is hardly the main topic. More important are clear hints that any call to follow a chain of responsibility to its source, for tragedies such as that just described, is unacceptable for some higher power. Implicitly, I am led to infer that there are certain questions which should not be asked, for fear of uncovering dark secrets. In turn I infer that those who close investigations and testimony must know something, at some level of consciousness, about those dark secrets. But . . . as they say . . .sunlight is the best disinfectant.

**How it Became Necessary for me to Write the Chapters to follow:**

In the next chapter I will give details of how the huge undertaking of this Royal Commission unfolded, with its origins 45 years ago, in very serious abuse in state institutions, and then in systematic suppression of investigations and litigation about serious crimes. My own points of departure included the disquiet I felt, growing during my period on RANZCP committees, amplified, I should say by details I recalled from early days in Otago, when collaborating with the Schizophrenia Fellowship. A deeper concern grew from the charade of an inquest in which I was involved, leading my focus to extend beyond our mental health system to problems in legal and judicial professions.

Two main hospitals were in focus. One was also the focus of many witnesses who appeared before the Commission. The other, down south near Dunedin was known to me from my time in Otago. There were other hospitals or institutions of concern, about which I have collected no evidence. The body of information now publicly available is vast, but we have yet to discover the depth to which the staff in the Royal Commission can digest and analyze all that information, accurately and fearlessly, regardless of the level of the agency to which the evidence might point on matters of responsibility. To the best of my knowledge, the topic of where ultimate responsibility lies has rarely if ever been explored in public by the Royal Commission; but this always was my target.

While the Royal Commission was in progress, I submitted several reports, all duly acknowledged. However, I never had a substantial response to any report from commission staff. At the time, I accepted it as necessary in terms of the commission’s regulations. In retrospect, knowing that I will not be permitted to bear witness in person, I feel that this was not satisfactory. I felt they were taking in all I had to give them yet giving nothing in return.

Almost all evidence on which these reports were based came from open sources, although it would indeed have been hard for anyone else to follow the complex steps by which I uncovered some of the more interesting detail. For a little of the evidence, I am myself the witness. Three crucial documents were declassified on my behalf by the Ministry of Foreign Affairs and Trade. None of my investigations needed to be done in a clandestine way. Usually when making enquiries, I have been explicit about what my motives are, and, when relevant, that I was expecting to be a witness in the Royal Commission on Abuse in Care

 I did expect that in due course these reports would be matters for face-to-face discussion with commission staff. I waited a long time. Early in 2021, I was invited to meet one staff member. I had met him earlier before he was involved with the Royal Commission. He was a skilled investigator with training as a lawyer, and experience as a journalist. In 2021, he was by then part of the research component of the commission which at the time had recently expanded greatly. A close collaborator of mine, who helped me immensely in early stages of my investigation had suggested that I too should be part of that research team. However, as I travelled into Wellington for that meeting, I thought ‘*That can’t be right. I will then have to sign a confidentiality agreement, limiting my ability to share what I had discovered*.’ When I met up with that staff member, it was in a café, not in any commission office. He was accompanied by a senior police officer, for reasons which have puzzled me. Was this staff member under surveillance by that police officer, to make sure he did not break rules of his being a staff member? - or was I somehow under surveillance? In any case the meeting was short. The most important part of the conversation defined what my relationship was to be with the commission. I stated that I did not want to be formally part of the research team, because I wanted to retain my freedom to publish whatever I wanted, at suitable times. I was told that, yes, that was what the Royal Commission also wanted. On reflection at the time, I considered that the commission wanted me to be independent so that, were there to be any criticism of their final report, they would be in a stronger position if it was known that they had received evidence from investigators who were truly independent, and in no way bound by the Commission’s disciplinary regulations. That was my inference at the time, but subsequent events lead me to question that inference. So now, I do not know why the commission did not encourage a stronger, more formal relationship with me, on whatever terms we might have been able to negotiate.

Early in the next year (18 January 2022) I was invited to a more formal discussion with two skilled lawyers. I went to the office address I had been given, along with a trusted friend and colleague. I call it ‘a discussion’, but it may be better called an ‘interview’, in that all the matters we discussed were contained in reports I had submitted. The two staff members divulged almost nothing which was not already in the public domain. The recorded discussion/interview extended over three hours and we covered many topics. At the time those two interviewers won my trust – mainly, but never absolutely. Both I and my colleague left there with a firm impression that this session, and the transcripts of the recording when they became available, would be a prelude to my preparing a formal witness statement, to be followed by my appearing in person at one of the commission’s public hearings. It was important to me that I appear in person, in part because personal testimony has an authenticity never captured by written documents, and partly because the fate of written documents delivered to a large somewhat opaque body like the Royal Commission, may disappear without trace, or be used selectively to construct a story quite different from that intended by the witness.

By August 2022, I had not heard back from the commission with transcripts of the interview, let alone any draft of a witness statement based thereon. I therefore wrote with some concern about the delay. Late in September, I received drafts of the transcripts prepared by machine from the recordings. They would have been largely incomprehensible to anyone except myself, and I re-interpreted them from memory of what happened at the interview. There was also an early draft of a witness statement. In correspondence associated with these attachments, my own messages conveyed very clearly to the recipient my expectation that this was a prelude to finalizing the witness statement, signing it, and then preparing to appear at a public hearing. However, it was not to be so. Over the next few weeks, I worked hard to decipher and improve the transcripts, and to improve and expand the witness statement. However, I did not sign the witness statement, because I wanted first to discuss remaining matters with commission staff.

On 8 November, there was an announcement with a sense of celebration, that the Royal Commission had recently held it last public hearing. I wrote immediately to express my disappointment that I had never been included as a witness. I received back a message which included the following

*Witness statements are one of several ways in which people can share their experiences with the Royal Commission. They are not the basis for survivors* *to participate in public hearings. I am sorry if this was communicated to you*.

*Witness statements, such as yours, are a significant contribution to our investigation, as they are helping us understand why the abuse occurred and how the government can make improvements moving forward.*

*There are no future hearings planned. I am sorry if this is disappointing to you, especially if you were under the impression that you would be participating in one It was not our intention for there to be any misunderstanding.*

*If you have any questions or wish to discuss this further, please let us know.*

There were many points in this to which I objected. On 9 November, I wrote back giving details of these points. I wrote of my sense of having been seriously misled. *‘The bond of trust, such as it was, which had been established earlier, is now broken.’* My colleague who accompanied me at the discussion in January is also quite clear that I had been misled. My guess is that this was not the intention of the two lawyers who conducted the interview. It was, I guess, a decision imposed at higher levels of the commission, once they realised the gravity of my allegations and the strength of the evidence on which they were based. I then spelt out what needed to be done by the commission, if it were at all possible, to rebuild that sense of trust. Specifically I listed items of evidence which, one way or another, had to be made public, as well as my major recommendations. I wrote ‘*If trust cannot be rebuilt, I am left with a dreadful fear, that the cover-up of where ultimate responsibility lay for heinous state crimes, will continue into the future, unaddressed’* I stated that the matter was urgent, and therefore imposed a deadline of two weeks from the date of sending that message. With no resolution, I stated, after that date, my alternative plans would start to unfold ‘*nationally and internationally*.’

It is of interest that that last sentence in the message I received stated ‘*If you have any questions or wish to discuss this further, please let us know.* So far there has been no response to my message, not even so much as an acknowledgement.

In my message I pointed out that I have not signed my witness statement. The Commission cannot therefore use any new evidence I had provided without asking my permission. However, I had signed no confidentiality agreement, so there appears to be no legal impediment to my telling my story in as careful and diligent manner as I think appropriate.

I have to say that it is of great concern that, despite the huge expense of this Royal Commission, there seems to be a reluctance on its part to explore the question on which I focus, the locus of ultimate responsibility. How can recurrence of the abuse documented by the Commission be prevented, if it never explores this question? However, the reader may be aware from the earlier part of this introductory chapter that omissions of this kind are relatively normal in such investigations.

**Forthcoming Chapters**

The sequence of chapters, of which this is the first, is my *alternative plan.* As I conclude this introductory chapter, I envisage twelve further chapters of similar size. I have sketched the contents for each chapter, but these are not yet finalized. The first to follow this one will be a synopsis of what has already been documented by witnesses to the Royal Commission, acknowledging both its achievements, and its failures, as apparent so far. Following this will be a chapter summarizing what I know of an outdated and dangerous manner of treating serious mental disorder called Deep Sleep Therapy. I cover the history of this treatment, it’s use after the second World War, mainly in Britain, and then its use in New Zealand, in the period on which our Royal Commission on Abuse in Care was focused. The third chapter will deal in detail with a person who I believe played an important role in how that abuse unfolded, but whose has hardly even been named in public hearings of the Royal Commission. To say he has been quietly forgotten is to be unduly generous. That he was never mentioned has been, I strongly suspect, deliberate connivance. In the fourth chapter, I deal with the dark history of the unholy alliance in the last century (especially during and after the second World War) between military intelligence agencies in several countries, and the profession of psychiatry. Mainly here, I avoid going into detail of recent evidence I have uncovered, relevant to the Royal Commission. This is history which should have been given greater emphasis by the Royal Commission. My fifth chapter deals with comparisons across all the evidence surveyed in. previous chapters. The analysis is complex, but my objective is to show that what happened in New Zealand, was part of a broader international pattern of wrongdoing, involving both professional psychiatry and military intelligence agencies. After that, the chapters will deal with prolific evidence, necessarily indirect so far, suggesting which agencies from overseas may have played a part in instigating some of the worst abuse documented in Royal Commission hearings, and how this was achieved. Then I will have chapters detailing how the cover-up continued, partly in the late 1970s, and partly more recently (even up to the present day while the Royal Commission has been in session). The penultimate chapter will itemize and discuss my own set of recommendations for institutional change, along with my thoughts about the psychology of Orwell’s ‘double think’. My final chapter addresses what I believe to be a necessary outcome of the huge investigation which the Royal Commission embarked upon five years ago – namely a nation-wide program for what I call ‘emotional and spiritual healing’ across Aotearoa New Zealand.

Apart from this introductory chapter, my intention is to release the chapters on my website (and I hope elsewhere), starting early in New Year 2023. I also hope that release of each chapter might be accompanied by a video-recorded interview, also to made available on-line. I believe I have a compelling story to tell.

**My Objectives in this Series of Chapters**

What then are the objectives and emphases of my investigations, prompted by various events in which I have been involved, recounted in preceding pages and now relevant to the Royal Commission on Abuse in Care? My primary objective is to make an important body of evidence available to the public; but there is a secondary objective. Inevitably there are gaps in the story. By going public in this way, I hope that others, readers with different experiences to share, who know other parts of this story, can help fill in some of those gaps. Long before the commission was established, my focus centred not only on details of abuse, which was sometimes important, but especially on where ultimate responsibility lay. In that context, I was not limited to the events documented by witnesses at the commission’s hearings. I draw on abuse and the like in other settings, in New Zealand and elsewhere, and on a great deal of study of the historical background to the abuse documented by the Commission. Although my chapters may start from evidence presented to the Royal Commission, I have a larger scene in mind.

My focus is not mainly on persons who could be held culpable, but on organizations and systems, whose structures allowed such things to happen. Generally, I avoid naming names; but the higher one goes in any hierarchy, the more do persons and systems become identical with each other. In such cases, I will name names. There is no point in not doing so, since they are easily identified from other things I will say.

Am I trying to undermine the credibility of Royal Commission when it makes its final report? Not really. It has achieved a great deal, but it has its own agenda and obviously its own constraints, which I do not understand, but which are not the same as mine. If what I write does in some way undermine the credibility of that final report, it is merely a side effect of what I write, not my intention, and frankly none of my business. However, the two weeks after I learned that I would not be asked to bear witness at a public hearing of the commission has seen a relatively easy change in my attitude to that Royal Commission. I am now non-committal: I no longer care so much about it, although until recently I certainly did. In the future, if I am asked, I may be able to re-engage with the commission, to play an active role.

I should explain the roots of my commitment here. I am a scientist, and I know the attitudes of scientists well, in all their diversity. In Britain, and possibly also in New Zealand, education in my day forced students to specialize at too early an age either within the sciences or in the humanities. There is a widespread view amongst scientists that it is superior to other areas of study, in that is solid and supposedly ‘objective’, unlike the ever-shifting sands of human values. I never fell for this line. Partly this may have been because it was my good fortune to study music at an early age; and music, if well taught, in subtle almost subversive ways, expands one’s emotional repertoire. Above that is my father’s influence. He was a physicist, whose research training was in one of the world’s most prestigious physics laboratories, at times when secrets of atomic structure were being revealed. Ten to fifteen years later, the practical impact of such essentially academic study changed the world, when the atom bomb detonated over Hiroshima. Physicists around the world then knew the agony of serious moral dilemmas. I grew up with that awareness scorched into my consciousness. I am old enough to connect with those days. Perhaps I see the ethical responsibility of scientists with greater clarity and immediacy than most scientists from recent generations. So, following this line, as a neuroscientist, I cannot separate the fascinating but valueless study of brain mechanisms from my ethical commitment to see scientific knowledge used with wisdom. The investigations mentioned in this introductory chapter and in those to follow only occasionally draw on my scientific expertise; but the strategies of my investigations are essentially the same as those honed over many decades of research into the theory of brain function; and the ethical commitment of one is naturally transferred to the other.

1. As an introduction to my ideas on this see: http://robertmiller-octspan.co.nz/octspan/?page\_id=638 [↑](#footnote-ref-1)
2. During the first World War, the celebrated Russian ballet dancer, Vaclav Nijinsky resided in Switzerland. He was driven mad by the reports of appalling slaughter and displayed his feelings in the most agonized dance performance. Eugen Bleuler saw him, gave him the diagnosis of schizophrenia and told his wife ‘You must divorce him immediately’. [↑](#footnote-ref-2)
3. The presiding judge also had a judicial role for one of the Pacific Islands. Some years later, the government of that island state, realising that its Chief Justice, who was Australian, was married to the leader of the island state’s opposition, dismissed him; and when three other justices from New Zealand (including the one we met at the mediation session) raised objections to this, they too were dismissed. The background to this is probably the increasing influence of China over Pacific Island states. [↑](#footnote-ref-3)
4. I know this, because I am in touch with two determined advocates, concerned about another area of iatrogenic hazard, and medical injustice. Early in 2022, they brought this issue before a Select Committee linked to our parliament. The outcome: Guess what? It was referred back to HDC, which was then to be arbiter of its own shortcomings. In other words, one more case of that ‘circular barn dance’ with which I am by now quite familiar. [↑](#footnote-ref-4)