Executive Summary

The Commission to Inquire into Child Abuse was established in 2000 with functions including the investigation of abuse of children in institutions in the State. It was dependent on people giving evidence which they did in large numbers. The Commission expresses its gratitude to all those who participated and contributed with their testimony and documents. The witnesses who came to the Confidential and the Investigation Committees ensured that the Inquiry had sufficient information to investigate the difficult issues that it was mandated to explore. The Commission was impressed by the dignity, courage and fortitude of witnesses who endeavoured to recall events that had happened many years ago.

This Report should give rise to debate and reflection. Although institutional care belongs to a different era, many of the lessons to be learned from what happened have contemporary applications for the protection of vulnerable people in our society.

The expression "abuse" is defined in section 1(i) of the Principal Act, as amended by section 3 of the 2005 Act, as:-

> *(a) the wilful, reckless or negligent infliction of physical injury on, or failure to prevent such injury to, the child,*
>
> *(b) the use of the child by a person for sexual arousal or sexual gratification of that person or another person,*
>
> *(c) failure to care for the child which results, or could reasonably be expected to result, in serious impairment of the physical or mental or development of the child or serious adverse effects on his or her behaviour or welfare, or*
>
> *(d) any other act or omission towards the child which results, or could reasonably be expected to result, in serious impairment of the physical or mental health or development of the child or serious adverse effects on his behaviour or welfare,*
>
> *and cognate words shall be construed accordingly.*

The Commission Report

The Commission Report consists of 5 Volumes:

Volumes I and II:	The Investigation Committee Report on Institutions
Volume III:	The Confidential Committee Report
Volume IV:	The Department of Education; Finance; Society and the Schools; Development of Childcare Policy in Ireland since 1970; Report on Witnesses Attending for Interview; Conclusions and Recommendations
Volume V:	The ISPCC, Expert Reports, Commission Personnel and Legislation

Volume I

Chapter 1 contains a general introduction to the Commission and its terms of reference. It explains the task it was required to do and how it set about doing it.

Chapters 2 and 3 trace the historical background to the Industrial and Reformatory school system. They describe a Victorian model of childcare that failed to adapt to Twentieth Century conditions and did not prioritise the needs of children. Children were committed by the Courts using procedures with the trappings of the criminal law. The authorities were unwilling to address the failings in the system or consider alternatives.

Chapter 4 sets out the Rules and Regulations for Certified Industrial Schools, which detailed what the Schools were required to do in terms of physical care for the children. These rules set out standards in respect of accommodation, clothing, diet, education and industrial training. They also set down strict guidelines for punishment that could be imposed by the Managers of residential schools.

This chapter also sets out fully the Department of Education Rules and Regulations regarding corporal punishment, which were contained in the 1933 Rules and Regulations and in various circulars issued by the Department over the years. They all emphasised that physical punishment was to be a last resort and that it should be kept to a minimum.

The Investigation Committee Report on Institutions

The period covered by the Investigation Committee Inquiry, 'the relevant period', is from 1936 to the present. However, the complaints come mostly from a period during which large scale institutionalisation was the norm, which was, in effect, the period between the Cussen Report (1936) and the Kennedy report (1970).

In early 2004, the Investigation Committee engaged in a process of consultation with religious congregations, complainants and legal representatives seeking to establish procedures that would enable it to complete its work within a reasonable time.

Investigations were conducted into all institutions where the number of complainants was more than 20.

Chapter 5 outlines some preliminary issues with regard to the Investigation Committee Report, including the ways in which the investigation was conducted and the oral hearings were organised. This chapter also deals with the possible contamination of evidence and the impact of factors such as lobby groups, Statute of Limitation amendments and length of time had on the investigation.

On the question of anonymity, the Commission took the decision to give pseudonyms to all respondents and potential respondents in the Report, including respondents who had been found guilty of offences in criminal trials. The identity of all complainants was also protected by the use of pseudonyms and by removing any identifiable biographical details.

Chapters 6 to 13 contain the reports on the Institutions owned and managed by the Congregation of the Christian Brothers. This Congregation was the largest provider of residential care for boys in the country and more allegations were made against this organisation than all of the other male Orders combined.

Chapter 6 gives an overview of the Congregation, including its foundation, its organisation and management and its funding. It also looks at the vows taken by religious Brothers and the impact of these vows on the care they gave to children in their Schools. The Chapter examines the

Congregation's own Rules regarding corporal punishment and discipline in its schools and outlines the strict limitations imposed by the Authorities on its members in the way they could administer punishments in their schools.

This Chapter also looks at the attitude of the Congregation to allegations of abuse and the apologies it issued. These apologies acknowledged that some abuse had taken place but failed to accept any Congregational responsibility for such abuse. Finally, this chapter examines the Congregation's engagement with this Commission which was co-operative in terms of production of documents but defensive in the way it responded to complaints. Chapter Six covers a number of issues that were common to all of the Christian Brothers' Institutions that were examined in Chapters 7 to 13 of Volume I.

Each of the individual school chapters follows a similar format. The School is described in general terms outlining its size, physical buildings, numbers of boys' resident, and numbers of staff. The chapters then go on to look at allegations under the headings of Physical, Sexual, Neglect and Emotional abuse. The report firstly examines the documented cases of abuse that were discovered to the Committee by the Congregation and then looks at the allegations made by complainants to the Committee.

Chapter 7 deals with Artane Industrial School in Dublin. Artane was founded in 1870 and was certified for 830 boys. This was almost four times the size of any other school in the State. The size of Artane and the regimentation and military-style discipline required to run it were persistent complaints by ex-pupils and ex-staff members alike. The numbers led to problems of supervision and control, and children were left feeling powerless and defenceless in the face of bullying and abuse by staff and fellow pupils. Although physical care was better than in some schools, it was still poorly provided and so imbued with the harshness of the underlying regime that children constantly felt under threat and fearful.

All of the witnesses who made allegations against Artane complained of physical abuse. This abuse is outlined in full both from the documents and the evidence of witnesses. Conclusions on physical abuse are contained at Paragraph 7.311 of Volume I and state that physical punishment of boys in Artane was excessive and pervasive and, because of its arbitrary nature, led to a climate of fear amongst the boys.

Paragraphs 7.312 to 7.548, investigate sexual abuse. Many of the details of this abuse were contained in the Congregations' own records that became known as the 'Rome Files' This chapter looks at these allegations and how they were handled in respect of Brothers who had been assigned to Artane at any time during the relevant period. The Committee heard evidence from ex-residents who alleged abuse and from Brothers and ex-Brothers, some of whom admitted sexual abuse.

The Conclusions on sexual abuse which are outlined at Paragraph 7.549 were that sexual abuse of boys in Artane by Brothers was a chronic problem. Complaints were not handled properly and the steps taken by the Congregation to avoid scandal and publicity protected perpetrators of abuse. The safety of children was not a priority at any time during the relevant period.

Neglect and emotional abuse were also found to have been features of Artane. The numbers of children made it impossible for any child to receive an adequate standard of care.

The chapter on Artane contains an analysis of a 1962 Report written by Fr Henry Moore who was a chaplain in Artane in the 1960s. Fr Moore gave evidence to the Committee and much of it confirmed evidence of complainants who were pupils there.

A report by Mr Ciaran Fahy, consulting engineer, is appended to the Artane chapter and describes the physical layout and structures of the Institution and contains some photographic records of the school.

Chapter 8 deals with another Christian Brothers' school, Letterfrack, County Galway. The school in Letterfrack was founded in 1885 and was situated in a remote hillside location in Connemara, miles away from Galway or from public transport. The remoteness of Letterfrack was a common theme of complainants and of Brothers who had worked there. It was an inhospitable, bleak, isolated institution accessable only by car or bicycle and out of reach for family or friends of boys incarcerated there.

Physical punishment was severe, excessive and pervasive and by being administered in public or within earshot of other children it was used as a means of engendering fear and ensuring control.

Sexual abuse was a chronic problem. For two thirds of the relevant period there was at least one sexual abuser in the school, for almost one third of the period there were two abusers in the school and at times there were three abusers working in Letterfrack at the same time. Two abusers were present for periods of 14 years each and the Congregation could offer no explanation as to how these Brothers could have remained in the School for so long undetected and unreported. Conclusions on Sexual Abuse in Letterfrack are outlined at Paragraph 8.461 of the Report.

A decision in 1954 to reduce numbers in Letterfrack to a bare minimum had serious repercussions for the physical welfare of the boys. Children were emotionally and physically neglected throughout the relevant period and those children who could have benefited from family contact were deprived of this because of the remoteness of Letterfrack's location. This isolation impacted on boys and Brothers who were posted there.

Chapter 9 contains the report into St Joseph's Industrial School, Tralee, Co Kerry. This School was established in 1862 and was certified for 145 boys. Serious allegations were outlined both in documents and in oral testimony about a Brother who was violent and dangerous over a number of years (Paragraph 9.46). This Brother was moved from a day school because his violence towards children was causing severe problems with their parents, and was moved to Tralee Industrial School. Such a move displayed a callous disregard for the safety of children in care. He went on to terrorise children in Tralee for over seven years.

Children were left unprotected and vulnerable to bullying by older boys and this was stated to be a particular problem in Tralee both in terms of physical and sexual abuse.

Sexual abuse by staff was not as persistent a problem in Tralee as in Artane or Letterfrack, although one Brother was cited by complainants and by Brothers who had been on the staff in Tralee as 'behaving inappropriately' with the boys. He was on the staff for 20 years and his behaviour was known to at least three Superiors who did not attempt to stop it.

One ex-Brother, Professor Tom Dunne, gave evidence about his experience of Tralee and he described a cold hostile culture where the boys were treated with harshness: 'It was a secret enclosed world, run on fear'.

Chapter 10 deals with Carriglea Park Industrial School in Dun Laoghaire, Co Dublin. This School was established in 1894 and closed in 1954. The Investigation Committee did not receive many complaints about this school which had closed early in the relevant period but the documents and the limited evidence from complainants and ex-staff members give an important insight into management practices within the Christian Brothers. A period of near-anarchy was tackled by the imposition of a harsh punitive regime which was facilitated by the transfer of Brothers with a known

propensity for severe punishment to the school. There was some evidence of a more enlightened approach towards education and aftercare in Carriglea particularly in the preparation of boys for Post Office examinations. There were substantial surplus funds in the School accounts when this School closed in 1954.

Chapters 11 and 12 deal with Glin and with Salthill Industrial Schools respectively. Both schools were the subject of a documentary investigation by the Investigation Committee but were not included in the Schools designated for oral hearings by the Committee.

Glin was a large Industrial School in Co Limerick with a population of over 200 boys during a substantial part of the relevant period. It was the subject of two detailed reports commissioned by the Christian Brothers and these were used to provide background information about the school. The documents revealed that a system of harsh and pervasive punishment existed in Glin during the relevant period. The documents also revealed that Brothers with a known propensity for sexual abuse were transferred to Glin indicating a serious indifference to the safety of children.

Salthill in Co Galway was the only Christian Brothers' Industrial School to survive beyond the mid-1970s. The Congregation handed over management of the School to the Western Health Board in 1995. The documents showed that violent Brothers who were moved around from one school to another continued their violent behaviour. In Salthill, one Brother, who had been described as cruel in Letterfrack, continued his severe treatment of boys in Salthill and another continued his harshness in schools he was assigned to after Salthill. Internal Christian Brothers' Reports identified a 'severity in attitude' towards the boys in the 1950s and the records would indicate a concern with six Brothers who had served in Salthill with regard to physical punishment.

The documents implicated five Brothers, one care worker who was a former resident, and another ex-resident who returned after discharge, in sexual abuse allegations. In particular, the Salthill report deals with a relatively recent allegation of sexual abuse against a Brother who had been transferred from Salthill 'following a grave indiscretion with one of the boys' in the early 1960s (Paragraph 12.63). The treatment of a boy who alleged sexual abuse against this Brother some twenty years later by Congregational Authorities was shameful and disturbing.

Chapter 13 deals with the final Christian Brothers' School investigated by the Committee, St Joseph's School for the Deaf, in Cabra. This was not an Industrial School but was a residential school for boys from the age of eight who were profoundly or partially deaf. This school was also investigated on a document only basis. It was the subject of Eastern Health Board Investigations in the 1980s which revealed disturbing levels of sexual abuse and peer sexual activity amongst boys who were resident there. These documents reveal a persistent failure on the part of school Authorities to protect children from bullying and abuse.

In addition, the documents revealed that physical punishment of these children continued into the mid-1990s and that staff were protected by management when physical abuse was discovered.

It is significant that the Industrial Schools owned and managed by the Christian Brothers did not keep a Punishment Book as was required by the Rules.

Chapter 14 looks at the career of a serial sexual and physical abuser, given the name of Mr John Brander, who taught children in the primary and secondary school sector in Ireland for 40 years. He was eventually convicted of sexual abuse in the 1980s.

He began his career as a Christian Brother and after three separate incidents of sexual abuse of boys, he was granted dispensation from his vows. This chapter goes on to describe this man's progress through six different schools where he physically terrorised and sexually abused children

in his classroom. At various times during his career, parents attempted to challenge his behaviour but he was persistently protected by diocesan and school authorities and moved from school to school. Complaints to the Department of Education were ignored. The Committee received a large number of complaints from individual national schools and the investigation conducted into the career of Mr Brander, apart from being shocking in itself, also illustrates the ease with which sexual predators could operate within the educational system of the State without fear of disclosure or sanction.

Chapter 15 reports on Daingean Reformatory, Co Offaly. This was the only boys' reformatory in the State for most of the relevant period and was managed by but not owned by the Oblates of Mary Immaculate.

The physical abuse of boys in Daingean was extreme. Floggings which were ritualised beatings should not have been tolerated in any institution and they were inflicted even for minor transgressions. Children who passed through Daingean were brutalised by the experience and some were damaged by it.

Apart from a cruel regime of punishment, Daingean was an anarchic Institution. It was run by gangs of boys who imposed their rules on the others and the supervision by the religious Brothers and Priests was minimal and ineffectual.

Serious questions were raised about two Brothers who were in the school for long periods but in general allegations of sexual abuse were concentrated on abuse by older boys. The gangland culture fostered the development of protective relationships between the boys and these relationships sometimes developed a sexual aspect. The boy seeking the protection had little option but to comply with the demands of the older boy and the authorities were dismissive of any complaints.

Chapter 16 deals with Marlborough House Detention Centre in Dublin. Boys were remanded to Marlborough House either pending sentencing or whilst waiting for transfer to an Industrial School or Reformatory. The boys were left for long hours with no recreation facilities, no schooling and no proper supervision. It was managed by the Department of Education who appointed a lay supervisor to the role of Manager.

Volume II

Volume II continues the Investigation Committee Report into individual institutions and begins with an investigation into the two institutions owned and managed by the Rosminian Order.

Chapter I looks at the founding and organisation of the Rosminian Order and its involvement in residential care in Ireland. The Rosminians adopted a different approach to the Commission than other Congregations. They sought to understand abuse, in contrast to other Congregations who sought to explain it. They accepted that abuse had occurred in their Institutions, that the Institutions in themselves were abusive and that the Order itself must bear responsibility for what occurred.

Chapter 2 deals with St Patrick's Industrial School in Upton, County Cork which was certified for 200 boys. Included in the documents discovered by the Rosminians were two Punishment Books for this school. One related to the 1889-1893 period and the other related to the period 1952 – 1963. This latter book contained clear documentary evidence of a harsh regime in Upton. The Order conceded that punishment was abusive and at times brutal.

The issue of sexual abuse in this institution emerged most strikingly through material that came to the Investigation Committee's attention following a search by the Order of material in their archive in Rome, which disclosed a considerable number of documents, 68 in all, dating from 1936 to 1968. They dealt with, among other things, 7 sexual abusers who worked in Upton. These documents provided a valuable contemporary account of how sexual abuse was dealt with.

Chapter 3 covers Ferryhouse, Clonmel, Co Tipperary, which was the second Industrial School owned and managed by the Rosminian Order. It opened in 1885 and was certified for 200 boys. There was no punishment book made available in respect of Ferryhouse and no documented evidence as to the severity of the regime there, although the Order have conceded that there was excessive and severe punishment in the Institution. Complainants spoke of a climate of fear and of harsh and at times brutal punishments.

The extent of sexual abuse in this institution was as serious and disturbing as in Upton. Two religious members of the Rosminian Order and one layman were convicted of sexual abuse of boys in Ferryhouse. Another religious who served in Ferryhouse was convicted of a crime committed elsewhere on a boy who had previously been a resident of Ferryhouse and who was then living in another Rosminian institution. These three religious offenders served in senior positions in Ferryhouse and the layman was a volunteer there for different periods of years between 1968 and 1988.

During almost all of the period covered by the inquiry, there was at least one sexual abuser present in Ferryhouse.

The living conditions in both schools were poor, inadequate and overcrowded although conditions in Ferryhouse did improve from the late 1970s. Children were underfed and badly clothed and received poor education and training.

Chapter 4 deals with Greenmount Industrial School, Co Cork, which was owned and managed by the Presentation Brothers. This school was founded in 1874 and closed in 1959 and was certified for 235 boys.

For some specific periods during its history, Greenmount operated a harsh and severe regime. The level of corporal punishment tolerated depended on the attitude of management at the time. Some Resident Managers were more severe than others.

The report into Greenmount contains a detailed analysis of an investigation into allegations of sexual abuse against two Brothers who were on the staff at the time. This matter was dealt with inadequately at the time and one of the Brothers went on to abuse in other schools he was assigned to.

Food clothing and accommodation were poor in Greenmount and education and aftercare were badly provided.

Chapter 5 deals with Lota which was a residential school for boys with special needs run by the Brothers of Charity in Glanmire, Co Cork.

The significant element in the account of Lota was the deeply disturbing accounts of sexual abuse of vulnerable children by religious staff. In addition, the indifference of the Congregational Authorities in addressing the issue facilitated the abuse in Lota for many years. In one case, a Brother who was known by the Congregation to have abused in England and was known to the police there, was brought back to Ireland and assigned a teaching position in Lota, where he worked for over 30 years. This Brother admitted to multiple sexual assaults of boys in the school. The circumstances of his return to Ireland and the handling of allegations against him whilst in Lota are a serious indictment of the Brothers of Charity. The Brothers have admitted that abuse took place but, as in the case of other Orders, they have not accepted Congregational responsibility for it.

Chapters 6 to 16 of Volume II cover 8 Industrial Schools run by Orders of nuns which catered mainly for girls, and boys under eight years. The largest providers of care to these children were the Sisters of Mercy, who ran a total of 26 Industrial Schools in the State during most of the relevant period.

Chapter 6 looks at the foundation and organisation of the Sisters of Mercy and looks at the personal vows taken by Sisters and the impact these had on the standard of care provided to children. It is a feature of the structure of this organisation that during the relevant period it was not a homogenous body but was made up of a number of separate convents each of which was independent of the other. It did not become a unified Congregation until the 1980s.

Chapter 7 deals with Goldenbridge Industrial School which was located in Inchicore in Dublin and was certified for 150 girls. Boys under eight were admitted in the late 1960s. Goldenbridge was a controversial institution and had been the subject of television and media discussion from 1995 onwards when the 'Dear Daughter' programme had been broadcast on RTE. Allegations of a severe, cruel regime were made where discipline was unrelenting and severe.

Unlike the Christian Brothers and to a lesser extent the Rosminians, the Sisters of Mercy retained almost no records of complaints or allegations against the School, or even any reports of internal inspections or reviews. The Goldenbridge report relies heavily on the oral testimony of witnesses both complainants and ex-staff members.

A high level of physical abuse was perpetrated by Religious and lay staff in Goldenbridge. The method of inflicting punishments and the implements used were cruel and excessive and physical punishment was an immediate response to even minor infractions. Children were in constant fear of beatings and in many cases were beaten for no apparent reason. A feature of this school was a rosary bead industry that was operated from the school. This industry was conducted in a way that imposed impossible standards on children and caused great suffering to many of them. It was a school that was characterised by a regime of extreme drudgery, both in terms of the rosary bead making and the daily workload of the children.

Goldenbridge was an emotionally abusive institution. Girls were humiliated and belittled on a regular basis and treated with contempt by some staff members. It was characterised by an absence of kindness or sympathy for the children.

Chapter 8 considers Cappoquin Industrial School, County Waterford which was owned and managed by the Sisters of Mercy. It was certified for 75 boys up to the age of ten. From 1970, it was allowed take girls as well as boys.

This institution was identified by the Department of Education Inspector as being particularly neglectful of the children in its care in the 1940s. Children were described as malnourished and underweight.

Cappoquin adapted to the Group Home system in the 1970s but it was marred by highly dysfunctional management throughout the 1970s and 1980s. Alcohol abuse and inappropriate relationships between senior personnel interfered significantly with the standard of care provided to the children. This period was marked by indifference on the part of the Community of Sisters in the convent attached to the school, which allowed a dangerous and neglectful situation to continue.

This chapter also deals with Passage West Industrial School Co Cork, in the context of an allegation of sexual abuse against a lay care worker who worked in both Institutions and who was subsequently convicted of abuse of children in Cappoquin.

Chapter 9 deals with Clifden, another Sisters of Mercy Industrial School in Co. Galway. It was certified as an Industrial School in 1872 and catered for up to 140 children..

Clifden was an institution that was strongly affected by the personality of the Resident Manager who was in office from 1936 to 1969. She was described by complainants and respondent witnesses as a strict, harsh woman who ruled and dominated all aspects of life in the institution. She treated the school as her personal domain and worked a punishing schedule with little help or support. She was unable to give the children the care they needed and used harsh physical punishment not just to correct misbehaviour, but also to enforce discipline and order. A significant feature of the evidence was the culture of detachment and lack of affection that was described by both respondent witnesses and complainants. Although there was a large community of nuns in the convent in the grounds of the industrial school, these Sisters had no contact with the children in care and appeared unable to help in the chronic under-staffing which was a problem in this school until the 1980s when numbers were reduced.

Chapters 10 deals with Newtownforbes, a Sisters of Mercy school located in County Longford that catered for up to 175 girls from infancy to 16 year olds. It repeated many of the problems identified in Clifden. It was consistently under-staffed with a heavy workload falling to the Resident Manager and much of the day to day work being done by the children themselves. Newtownforbes was severely criticised by Department of Education Inspections in the 1940s for serious neglect and abuse of children who were found with bruising that was not satisfactorily explained. Conditions improved into the 1950s and 1960s but it was a strictly regimented school that used corporal punishment to punish and to maintain order. There was a heavy emphasis on domestic chores and this together with childcare duties impeded the education of many children. Children were undermined and emotionally neglected by a regime that did not offer kindness or encouragement to children who had no-one else to look out for them.

Chapter 11 considers Dundalk Industrial School which was founded by the Sisters of Mercy in 1881 and was located in the centre of town of Dundalk in Co Louth. It was certified for 100 children but for most of the relevant period it had no more than 40 or 50 children and this had a

considerable impact on the atmosphere in the school. Although like other Sister of Mercy Schools, Dundalk came in for criticism in the 1940s, conditions improved in the 1950s and 1960s and significantly there was some evidence that it did not depend on physical punishment to maintain order. Indeed it appeared to keep corporal punishment to a minimum and although there were individual accounts of severe punishment, in general it was not an abusive institution. It was, however, seriously understaffed and supervision and physical care was affected by this lack of staffing. It was not an ideal institution but it was a more benign place than many other such schools.

Chapter 12 gives an outline of the foundation and organisation of the Sisters of Charity who ran two Industrial Schools in Kilkenny, St Patrick's and St Joseph's as well as a review of its response to allegations of abuse that have arisen.

Chapter 13 deals with St Patrick's Industrial School which was founded in 1879 and accommodated 186 boys up to the age of 10. A significant feature of this school was the very young ages of the children and the large group of them all being cared for by a small number of nuns. Because they were so young when they were there, witnesses tended to remember specific episodes rather than have overall memories of St Patrick's. Some of these incidents pointed to a regime that was harsh and unpredictable with corporal punishment the usual response to misbehaviour. Three male complainants described incidents of sexual abuse and the significant factor in each account was the child's inability to confide to the Sister who was caring for him. Men who were employed in the school appeared to have ready access to these small boys and there was no awareness of the risks posed by this.

Chapter 14 deals with St Joseph's Kilkenny which was founded in 1872 and catered for 130 children. The Sisters of Charity were unique in that they sought out training and guidance in childcare and introduced innovations into their two schools in Kilkenny that were unusual at the time. In particular, they recognised the value of the group system which they introduced to St Joseph's in the late 1940s.

In general this was a well run institution but it was dogged at two separate periods in its history by serious instances of sexual abuse and the Congregation did not deal with these appropriately or with the children's best interests in mind. In 1954, a handyman who had been employed in the school for the previous 30 years was discovered to have been grossly sexually abusing girls from as young as eight years old. An investigation which was conducted by the Department of Education, confirmed the abuse but the children concerned were offered no comfort and the perpetrator, although dismissed from the school, was not reported to the Gardai.

The second period in which sexual abuse arose in St Joseph's was during the 1970s after the school admitted boys, when two care workers who were sexually abusing boys were dismissed. Both men went on to abuse again after leaving St Joseph's and the failure of the Congregation to deal decisively with these men was a factor in this.

Chapters 15 and 16 are brief reviews of documentary evidence in relation to two schools that offered residential care to deaf girls: St Mary's Girls Cabra which was run by the Dominican Order of Nuns and Beechpark run by the Daughters of Liege. Oral hearings were not conducted into these schools and there was not a significant amount of documentary material discovered to the Committee. Most allegations of abuse referred to the harshness with which the policy of oralism was imposed on children who were deaf and who instinctively used sign language as well. Whilst the wisdom of imposing oralism was a separate matter and one which the Committee could not comment on, the methods of enforcing it were at times too severe.

In general however, the standard of care in these schools was good and particular efforts were made to ensure that the children received the best possible education.

In general, girls' schools were not as physically harsh as boys' schools and there was no persistent problem of sexual abuse in girls' schools although there was at best naiveté and at worst indifference in the way girls were sent out to foster families. A number of girls did experience sexual abuse at the hands of 'godfathers' which they were either unable to report or were disbelieved when they did report it.

There was a high level of emotional abuse in girls' schools, which was a consistent feature of these institutions.

Volume III

Confidential Committee Report

The Confidential Committee heard evidence from 1090 men and women who reported being abused as children in Irish institutions. Abuse was reported to the Committee in relation to 216 school and residential settings including Industrial and Reformatory Schools, Children's Homes, hospitals, national and secondary schools, day and residential special needs schools, foster care and a small number of other residential institutions, including laundries and hostels**.** 791 witnesses reported abuse to Industrial and Reformatory Schools and 259 witnesses reported abuse in the range of other institutions.

The 1090 witness reports relate to the period between 1914 and 2000, of which 23 refer to abuse experienced prior to 1930 or after 1990.

Chapter 2 describes the methodology used by the Committee. The majority of hearings were conducted in the CICA offices in Dublin. There were 166 hearings held in other locations in Ireland and overseas.. 396 witnesses lived overseas, of whom 328 travelled to hearings in Dublin. Witnesses who attended hearings with the Confidential Committee chose to give their evidence in confidence and their evidence was uncontested. The work of the Confidential Committee was bound by strict rules of confidentiality and the Committee's report does not identify or contain information that could lead to the identification of witnesses, or the persons against whom they made allegations or the institutions in which they alleged they were abused, or any other person.

The most frequently cited reasons given by witnesses for attending to give evidence to the Confidential Committee were to have the abuse they experienced as children officially recorded and to tell their story. Most witnesses expressed the hope that a formal record of their experiences would contribute to a greater understanding of the circumstances in which such abuse occurs and would assist in the future protection of children.

Chapter 3 addresses the social and demographic profile of witnesses from Industrial and Reformatory Schools.

Over 75% of witnesses to the Confidential Committee were from two-parent households; the remaining witnesses were the children of single mothers or had no information about their family of origin. Most witnesses had lived with their parents or extended family members for some period prior to their admission to out-of-home care and came from families where there the average family size was 6 children. The majority of witnesses reported their parents' occupational status as unskilled.

77% of witnesses were aged over 50 years and 3% were under 30 years of age when they gave their evidence to the Confidential Committee. More than 50% of witnesses who were in out-of -home care placements for substantial periods of their childhood were first admitted when they were less than 5 years old and their average length of stay in out-of-home care was 9 years.

Chapters 7, 9 and 13 to 18 set out the Confidential Committee abuse reports.

Witnesses reported being physically, sexually and emotionally abused, and neglected by religious and lay adults who had responsibility for their care, and by others in the absence of adequate care and supervision. Many of the 216 named settings were the subject of repeated reports of abuse. In excess of 800 individuals were identified as physically and/or sexually abusing the witnesses as children in those settings. Neglect and emotional abuse were often described as endemic within institutions where there was a systemic failure to provide for children's safety and welfare.

Witnesses gave evidence of abuse they directly experienced and also of abuse to others which they witnessed. A number of witnesses stated that they wished to report abuse in senior schools only as they had general but no detailed recall of abuse in their junior schools. Other witnesses wished only to report memories of extreme abuse.

Physical abuse

More than 90% of all witnesses who gave evidence to the Confidential Committee reported being physically abused while in schools or out-of-home care. Physical abuse was a component of the vast majority of abuse reported in all decades and institutions and witnesses described pervasive abuse as part of their daily lives. They frequently described casual, random physical abuse but many wished to report only the times when the frequency and severity were such that they were injured or in fear for their lives. In addition to being hit and beaten, witnesses described other forms of abuse such as being flogged, kicked and otherwise physically assaulted, scalded, burned and held under water. Witnesses reported being beaten in front of other staff, residents, patients and pupils as well as in private. Physical abuse was reported to have been perpetrated by religious and lay staff, older residents and others who were associated with the schools and institutions. There were many reports of injuries as a result of physical abuse, including broken bones, lacerations and bruising.

Sexual abuse

Sexual abuse was reported by approximately half of all the Confidential Committee witnesses. Acute and chronic contact and non-contact sexual abuse was reported, including vaginal and anal rape, molestation and voyeurism in both isolated assaults and on a regular basis over long periods of time. The secret nature of sexual abuse was repeatedly emphasised as facilitating its occurrence. Witnesses reported being sexually abused by religious and lay staff in the schools and institutions and by co-residents and others, including professionals, both within and external to the institutions. They also reported being sexually abused by members of the general public, including volunteer workers, visitors, work placement employers, foster parents, and others who had unsupervised contact with residents in the course of everyday activities. Witnesses reported being sexually abused when they were taken away for excursions, holidays or to work for others. Some witnesses who disclosed sexual abuse were subjected to severe reproach by those who had responsibility for their care and protection. Female witnesses in particular described, at times, being told they were responsible for the sexual abuse they experienced, by both their abuser and those to whom they disclosed abuse.

Neglect

Neglect was frequently described by witnesses in the context of physical, sexual and emotional abuse in addition to accounts of inadequate heating, food, clothing and personal care. Neglect of a child's care and welfare occurred both by actions and inactions by those who had a responsibility and a duty of care to protect and nurture them. Witnesses reported that the failure to provide for their safety, education, development and aftercare had implications for their health, employment, social and economic status in later life. The neglect reported by witnesses referred to the actions and omissions of individual staff and the organisations within which they operated. Untreated injuries and medical conditions were reported to have caused permanent impairment.

Emotional abuse

Emotional abuse was reported by witnesses in the form of lack of attachment and affection, loss of identity, deprivation of family contact, humiliation, constant criticism, personal denigration, exposure to fear and the threat of harm. A frequently identified area of emotional abuse was the separation from siblings and loss of family contact. Witnesses were incorrectly told their parents were dead and were given false information about their siblings and family members. Many witnesses recalled the devastating emotional impact and feeling of powerlessness associated with

observing their co-residents, siblings or others being abused. This trauma was acute for those who were forced to participate in such incidents. Witnesses believed emotional abuse contributed to difficulties in their social, psychological and physical well-being at the time and in the subsequent course of their lives.

Knowledge and disclosure

Parents, relatives and others knew that children were being abused as a result of disclosures and their observation of marks and injuries. Witnesses believed that awareness of the abuse of children in schools and institutions existed within society at both official and unofficial levels. Professionals and others including Government Inspectors, Gardai, general practitioners, and teachers had a role in relation to various aspects of children's welfare while they were in schools and institutions. Local people were employed in most of the residential facilities as professional, care and ancillary staff. In addition, members of the public had contact with children in out-of-home care in the course of providing services to the institutions both at a formal and informal level. Witnesses commented that while many of those people were aware that life for children in the schools and institutions was difficult they failed to take action to protect them.

Contemporary complaints were made to the School authorities, the Gardaí, the Department of Education, Health Boards, priests of the parish and others by witnesses, their parents and relatives. Witnesses reported that at times protective action was taken following complaints being made. In other instances complaints were ignored, witnesses were punished, or pressure was brought to bear on the child and family to deny the complaint and/or to remain silent. Witnesses reported that their sense of shame, the power of the abuser, the culture of secrecy and isolation and the fear of physical punishment inhibited them in disclosing abuse.

Children with special needs

Children with learning disability, physical and sensory impairments and children who had no known family contact were especially vulnerable in institutional settings. They described being powerless against adults who abused them, especially when those adults were in positions of authority and trust. Impaired mobility and communication deficits made it impossible to inform others of their abuse or to resist it. Children who were unable to hear, see, speak, move or adequately express themselves were at a complete disadvantage in environments that did not recognise or facilitate their right to be heard.

Chapter 11 and Sections of Chapters 13 to 18 deal with the effects of abuse on later life. The Confidential Committee heard evidence both of childhood abuse and the continuing effects of such abuse on witnesses. The enduring impact of childhood abuse was described by many witnesses who, while reporting that as adults they enjoyed good relationships and successful careers, had learned to live with their traumatic memories. Many other witnesses reported that their adult lives were blighted by childhood memories of fear and abuse. They gave accounts of troubled relationships and loss of contact with their siblings and extended families. Witnesses described parenting difficulties ranging from being over-protective to being harsh and commented on the intergenerational sequelae of their childhood abuse. Approximately half of the witnesses reported having attended counselling services, either currently or in the past.

Witnesses also described lives marked by poverty, social isolation, alcoholism, mental illness, sleep disturbance, aggressive behaviour and self harm. Approximately 30% of the witnesses described a constellation of ongoing, debilitating mental health concerns for example; suicidal behaviour, depression, alcohol and substance abuse and eating disorders, which required treatment including psychiatric admission, medication and counselling.

Many witnesses stated that their childhood experience of abuse and emotional deprivation inhibited their capacity to form stable, secure and nurturing relationships in adult life. They

described a continuing sense of isolation and inability to trust others. However, a high proportion of male and female witnesses described marriages or long-term relationships that endured despite often severe interpersonal difficulties.

70% of witnesses received no second-level education and, while many witnesses reported having successful careers in business and professional fields, the majority of witnesses seen by the Committee reported being in manual and unskilled occupations for their entire working lives.

Chapter 10 and **Sections of Chapters 13 to 18** deal with positive experiences. Among the positive experiences reported by witnesses was the kindness of some religious and lay staff in the schools and institutions, including a number who provided support in times of difficulty after they were discharged. Many emphasised the enormous difference that just a kind word or gesture made to their daily lives. Family contact was greatly valued. Friendships and contact with kind 'holiday' families sustained some witnesses at the time and in later life.

In conclusion, the Confidential Committee heard evidence that children were severely abused and neglected by those with responsibility for their safety and welfare. Those in care without family contact and with special needs were most at risk. Witnesses reported that the abuse experienced in childhood had an enduring impact on their lives.

Volume IV

Chapter 1 The Department of Education

The Department of Education had legal responsibility under the Children Act 1908 for all children committed to the Industrial and Reformatory Schools. The Minister had the power to grant and withdraw certification, and when certified the institution had to accept the Rules and Regulations set out by the Department. They defined the standards that were acceptable for accommodation, clothing, diet, instruction, training, visits by family and home visits, and the time of discharge. The Department's inspectors had the duty of ensuring these regulations were complied with.

The Minister also determined the amount of money paid for the upkeep of the children. The amount was negotiated periodically with the Congregations.

This chapter examines the extent to which the Department ensured its Rules and Regulations were upheld by the institutions, and the basic standards set for the children taken into the care of the State were being met.

The Department had too little information because the inspections were too few and too limited in scope. If the Department had been in possession of better information about the Schools, it would have been in a stronger position to exercise control. The officials were aware that abuse occurred in the Schools and they knew the education was inadequate and the industrial training was outdated.

The Department of Education should have exercised more of its ample legal powers over the Schools in the interests of the children. The power to remove a Manager given to the Department in 1941 should have been exercised or even threatened on more than the handful of occasions when it was invoked, which would have emphasised the State's right to intervene on behalf of children in its care.

The Department was lacking in ideas about policy. It made no attempt to impose changes that would have improved the lot of the detained children. Indeed, it never thought about changing the system.

The failures by the Department that are catalogued in the chapters on the schools can also be seen as tacit acknowledgment by the State of the ascendancy of the Congregations and their ownership of the system. The Departments' Secretary General, at a public hearing, told the Investigation Committee that the Department had shown a 'very significant deference' towards the religious Congregations. This deference impeded change, and it took an independent intervention in the form of the Kennedy Report in 1970 to dismantle a long out-dated system.

Chapter 2 Finance

It was the responsibility of the Department of Education to ensure adequate funding for the provision of minimum standards of care for children in the care of the State. This chapter examines the system for funding the schools, the sufficiency of funding, the way the funding was administered and it looks at the relationship between the Department of Education, the Resident Managers and the Department of Finance.

The system was based on the capitation grant, with the State paying a sum for each child in an institution. An important question is why this capitation system persisted in Ireland long after its abandonment in England after it was shown that a budget system was more efficient and of greater benefit to the children.

The adequacy of funding to provide for the care of children to the standard required by the regulations is examined in the Mazars' Report, prepared for the Investigation Committee, and in the responses to it by the Congregations.

Broadly, the Committee concluded that large, mainly boys' schools with big productive farms, industrial training geared to the needs of the school and sufficient numbers to allow economies of scale to apply, were well resourced. These schools should have been able to provide a good standard of care. However, the evidence indicates that the children in these schools were some of the most poorly provided for.

The Committee also concluded that some schools struggled valiantly to survive, some did not, yet the negotiations with the Department of Education made no distinction and the larger boys' schools dominated the debate. The Department of Finance could see that not all schools were the same and sought to distinguish those in genuine need. The Resident Managers Association, however, did not co-operate and thereby condemned many children in the less well resourced Institutions to needless poverty.

Chapter 3 Society and the Schools.
This chapter by Prof David Gwynn Morgan of University College Cork, discusses the social, economic and family background of children in the schools; other institutions for children in care; facts and figures about the system; independent monitoring; family links and the closure of the schools.

Chapter 4 Residential Child Welfare in Ireland 1965 - 2008
Dr Eoin O'Sullivan of Trinity College Dublin, prepared a report outlining the policy, legislation and practice in residential child welfare in Ireland, from the Kennedy Report to the present day.

This paper provides a review of the evolution of policy, legislation and practice in relation to child welfare, with a particular emphasis on residential childcare from the mid-1960s to the present. It delineates a number of the key shifts in the organisation of child welfare in Ireland that have led to the current configuration of services. The paper focuses on the specifics of residential childcare and by utilising the archival records of the Government Departments centrally concerned with this area of public policy, the Departments of Health and Education, supplemented by a secondary literature, outlines the intent and shifting concerns of policy makers, policy activists and service providers during the period under review, in particular the period between 1965 and 1975.

Chapter 5 Report on Interviews
A large number of witnesses who did not proceed to oral hearing were interviewed by members of the Investigation Committee legal team and their untested evidence has been summarised in this section of the Report. Apart from Industrial Schools and Reformatories, evidence was heard in relation to orphanages, hospitals, national schools, special schools and other institutions that provided out of home care for children.

Chapter 6 Conclusions of the Commission
These Conclusions are included at the end of this Executive Summary.

Chapter 7 Recommendations of the Commission
These Recommendations are included at the end of this Executive Summary.

Volume V

The Irish Society for the Prevention of Cruelty to Children (ISPCC)
The primary purpose of the ISPCC was the protection of children. Two of its basic duties were:

> To prevent the public and private wrongs to children, and the corruption of their morals.
>
> To take action for the enforcement of the laws for their protection.

Throughout most of the relevant period the Society appointed inspectors, usually recruited from retired police and army officers, who were answerable to a local committee of volunteers. Known colloquially as 'cruelty men', they dealt with problems in their area arising from social and environmental deprivation.

The Committee examined the evidence for the allegation that too many children were sent needlessly to the Industrial Schools by the ISPCC. It concluded:

> The extent of the ISPCC involvement in committing children to industrial schools cannot be accurately ascertained but it can be stated as significant.
>
> The lack of documentation available has rendered it impossible to determine precisely the numbers of children who were committed to Industrial Schools by the Society.
>
> The stated philosophy of the Society was to keep families together and committal to an industrial school was seen as a last resort, but there was no proper monitoring or supervision of Inspectors, so Inspectors may have been overly zealous in sending children to industrial schools.

The Psychological Adjustment of Adult Survivors of Institutional Abuse in Ireland
This Part contains the report on the research survey on institutional abuse that was announced at the first public meeting of the Commission in June 2000 and was carried out by Prof Alan Carr and his team from University College Dublin.

Gateways to the Institutions
This Part presents statistical information and analysis in relation to the committal of children to Industrial and Reformatory Schools researched by Prof David Gwynn Morgan of University College Cork

Health Records of Children in Institutions
This Part is a research paper by Prof Anthony Staines of Dublin City University and his team into health records of children in Institutions and it is followed by responding submissions.

Review of Issues of Historical Context.
This Part is a review by Prof Diarmaid Ferriter, University College Dublin that considers the issue of institutional abuse from a historical perspective.

Residential Childcare in England,1948 – 1975: A History and Report.
A review of developments in England in relation to residential childcare by Mr Richard Rollinson.

The remaining parts of the volume list the Commission Personnel 2004 – 2009 and the Commission to Inquire into Child Abuse Acts 2000 – 2005.

Conclusions

1. **Physical and emotional abuse and neglect were features of the institutions. Sexual abuse occurred in many of them, particularly boys' institutions. Schools were run in a severe, regimented manner that imposed unreasonable and oppressive discipline on children and even on staff.**

2. **The system of large-scale institutionalisation was a response to a nineteenth century social problem, which was outdated and incapable of meeting the needs of individual children. The defects of the system were exacerbated by the way it was operated by the Congregations that owned and managed the schools. This failure led to the institutional abuse of children where their developmental, emotional and educational needs were not met.**

3. **The deferential and submissive attitude of the Department of Education towards the Congregations compromised its ability to carry out its statutory duty of inspection and monitoring of the schools. The Reformatory and Industrial Schools Section of the Department was accorded a low status within the Department and generally saw itself as facilitating the Congregations and the Resident Managers.**

4. **The capital and financial commitment made by the religious Congregations was a major factor in prolonging the system of institutional care of children in the State. From the mid 1920s in England, smaller more family-like settings were established and they were seen as providing a better standard of care for children in need. In Ireland, however, the Industrial School system thrived.**

5. **The system of funding through capitation grants led to demands by Managers for children to be committed to Industrial Schools for reasons of economic viability of the institutions.**

6. **The system of inspection by the Department of Education was fundamentally flawed and incapable of being effective.**

   The Inspector was not supported by a regulatory authority with the power to insist on changes being made.

   There were no uniform, objective standards of care applicable to all institutions on which the inspections could be based.

   The Inspector's position was compromised by lack of independence from the Department.

   Inspections were limited to the standard of physical care of the children and did not extend to their emotional needs. The type of inspection carried out made it difficult to ascertain the emotional state of the children.

   The statutory obligation to inspect more than 50 residential schools was too much for one person.

   Inspections were not random or unannounced: School Managers were alerted in advance that an inspection was due. As a result, the Inspector did not get an accurate picture of conditions in the schools.

   The Inspector did not ensure that punishment books were kept and made available for inspection even though they were required by the regulations.

   The Inspector rarely spoke to the children in the institutions.

7. **Many witnesses who complained of abuse nevertheless expressed some positive memories: small gestures of kindness were vividly recalled.** A word of consideration or encouragement, or an act of sympathy or understanding had a profound effect. Adults in their sixties and seventies recalled seemingly insignificant events that had remained with them all their lives. Often the act of kindness recalled in such a positive light arose from the simple fact that the staff member had not given a beating when one was expected.

8. **More kindness and humanity would have gone far to make up for poor standards of care.**

Physical abuse

9. **The Rules and Regulations governing the use of corporal punishment were disregarded with the knowledge of the Department of Education.**

The legislation and the Department of Education guidelines were unambiguous in the restrictions placed on corporal punishment. These limits however, were not observed in any of the schools investigated. Complaints of physical abuse were frequent enough for the Department of Education to be aware that they referred to more than acts of sporadic violence by some individuals. The Department knew that violence and beatings were endemic within the system itself.

10. **The Reformatory and Industrial Schools depended on rigid control by means of severe corporal punishment and the fear of such punishment.**

The harshness of the regime was inculcated into the culture of the schools by successive generations of Brothers, priests and nuns. It was systemic and not the result of individual breaches by persons who operated outside lawful and acceptable boundaries. Excesses of punishment generated the fear that the school authorities believed to be essential for the maintenance of order. In many schools, staff considered themselves to be custodians rather than carers.

11. **A climate of fear, created by pervasive, excessive and arbitrary punishment, permeated most of the institutions and all those run for boys. Children lived with the daily terror of not knowing where the next beating was coming from.**

Seeing or hearing other children being beaten was a frightening experience that stayed with many complainants all their lives.

12. **Children who ran away were subjected to extremely severe punishment.**

Absconders were severely beaten, at times publicly. Some had their heads shaved and were humiliated. Details were not reported to the Department, which did not insist on receiving information about the causes of absconding. Neither the Department nor the school management investigated the reasons why children absconded even when schools had a particularly high rate of absconding. Cases of absconding associated with chronic sexual or physical abuse therefore remained undiscovered. In some instances all the children in a school were punished because a child ran away which meant that the child was then a target for mistreatment by other children as well as the staff.

13. **Complaints by parents and others made to the Department were not properly investigated.**

Punishments outside the permitted guidelines were ignored and even condoned by the Department of Education. The Department did not apply the standards in the rules and their own guidelines when investigating complaints but sought to protect and defend the religious Congregations and the schools.

14. **The boys' schools investigated revealed a pervasive use of severe corporal punishment.**
Corporal punishment was the option of first resort for breaches of discipline. Extreme punishment was a feature of the boys' schools. Prolonged, excessive beatings with implements intended to cause maximum pain occurred with the knowledge of staff management.

15. **There was little variation in the use of physical beating from region to region, from decade to decade, or from Congregation to Congregation.**
This would indicate a cultural understanding within the system that beating boys was acceptable and appropriate. Individual Brothers, priests or lay staff who were extreme in their punishments were tolerated by management and their behaviour was rarely challenged.

16. **Corporal punishment in girls' schools was pervasive, severe, arbitrary and unpredictable and this led to a climate of fear amongst the children.**
The regulations imposed greater restrictions on the use of corporal punishment for girls. Schools varied as to the level of corporal punishment that was tolerated on a day-to-day basis. In some schools a high level of ritualised beating was routine whilst in other schools lower levels of corporal punishment were used. The degree of reliance on corporal punishment depended on the Resident Manager, who could be a force for good or ill, but almost all institutions employed fear of punishment as a means of discipline. Some Managers administered excessive punishment themselves or permitted excesses by religious and lay staff. Girls were struck with implements designed to maximise pain and were struck on all parts of the body. The prohibition on corporal punishment for girls over 15 years was generally not observed.

17. **Corporal punishment was often administered in a way calculated to increase anguish and humiliation for girls.**
One way of doing this was for children to be left waiting for long periods to be beaten. Another was when it was accompanied by denigrating or humiliating language. Some beatings were more distressing when administered in front of other children and staff.

Sexual abuse

18. **Sexual abuse was endemic in boys' institutions. The situation in girls' institutions was different. Although girls were subjected to predatory sexual abuse by male employees or visitors or in outside placements, sexual abuse was not systemic in girls' schools.**

19. **It is impossible to determine the full extent of sexual abuse committed in boys' schools. The schools investigated revealed a substantial level of sexual abuse of boys in care that extended over a range from improper touching and fondling to rape with violence. Perpetrators of abuse were able to operate undetected for long periods at the core of institutions.**

20. **Cases of sexual abuse were managed with a view to minimising the risk of public disclosure and consequent damage to the institution and the Congregation. This policy resulted in the protection of the perpetrator. When lay people were discovered to have sexually abused, they were generally reported to the Gardai. When a member of a Congregation was found to be abusing, it was dealt with internally and was not reported to the Gardaí.**
The damage to the children affected and the danger to others were disregarded. The difference in treatment of lay and religious abusers points to an awareness on the part of Congregational authorities of the seriousness of the offence, yet there was a reluctance to confront religious who offended in this way. The desire to protect the reputation of the Congregation and institution was paramount. Congregations asserted that knowledge of sexual abuse was not available in society

at the time and that it was seen as a moral failing on the part of the Brother or priest. This assertion, however, ignores the fact that sexual abuse of children was a criminal offence.

21. **The recidivist nature of sexual abuse was known to religious authorities.**
The documents revealed that sexual abusers were often long-term offenders who repeatedly abused children wherever they were working. Contrary to the Congregations' claims that the recidivist nature of sexual offending was not understood, it is clear from the documented cases that they were aware of the propensity for abusers to re-abuse. The risk, however, was seen by the Congregations in terms of the potential for scandal and bad publicity should the abuse be disclosed. The danger to children was not taken into account.

22. **When confronted with evidence of sexual abuse, the response of the religious authorities was to transfer the offender to another location where, in many instances, he was free to abuse again. Permitting an offender to obtain dispensation from vows often enabled him to continue working as a lay teacher.**
Men who were discovered to be sexual abusers were allowed to take dispensation rather than incur the opprobrium of dismissal from the Order. There was evidence that such men took up teaching positions sometimes within days of receiving dispensations because of serious allegations or admissions of sexual abuse. The safety of children in general was not a consideration.

23. **Sexual abuse was known to religious authorities to be a persistent problem in male religious organisations throughout the relevant period.**
Nevertheless, each instance of sexual abuse was treated in isolation and in secrecy by the authorities and there was no attempt to address the underlying systemic nature of the problem. There were no protocols or guidelines put in place that would have protected children from predatory behaviour. The management did not listen to or believe children when they complained of the activities of some of the men who had responsibility for their care. At best, the abusers were moved, but nothing was done about the harm done to the child. At worst, the child was blamed and seen as corrupted by the sexual activity, and was punished severely.

24. **In the exceptional circumstances where opportunities for disclosing abuse arose, the number of sexual abusers identified increased significantly.**
For a brief period in the 1940s, boys felt able to speak about sexual abuse in confidence at a sodality that met in one school. Brothers were identified by the boys as sexual abusers and were removed as a result. The sodality was discontinued. In another school, one Brother embarked on a campaign to uncover sexual activity in the school and identified a number of religious who were sexual abusers. This indicated that the level of sexual abuse in boys' institutions was much higher than was revealed by the records or could be discovered by this investigation. Authoritarian management systems prevented disclosures by staff and served to perpetuate abuse.

25. **The Congregational authorities did not listen to or believe people who complained of sexual abuse that occurred in the past, notwithstanding the extensive evidence that emerged from Garda investigations, criminal convictions and witness accounts.**
Some Congregations remained defensive and disbelieving of much of the evidence heard by the Investigation Committee in respect of sexual abuse in institutions, even in cases where men had been convicted in court and admitted to such behaviour at the hearings.

26. **In general, male religious Congregations were not prepared to accept their responsibility for the sexual abuse that their members perpetrated.**
Congregational loyalty enjoyed priority over other considerations including safety and protection of children.

27. **Older boys sexually abused younger boys and the system did not offer protection from bullying of this kind.**
There was evidence that boys who were victims of sexual abuse were physically punished as severely as the perpetrator when the abuse was reported or discovered. Inevitably, boys learned to suffer in silence rather than report the abuse and face punishment.

28. **Sexual abuse of girls was generally taken seriously by the Sisters in charge and lay staff were dismissed when their activities were discovered. However, nuns' attitudes and mores made it difficult for them to deal with such cases candidly and openly and victims of sexual assault felt shame and fear of reporting sexual abuse.**
Girls who were abused reported that it happened most often when they were sent to host families for weekend, work or holiday placements. They did not feel able to report abusive behaviour to the Sisters in charge of the schools for fear of disbelief and punishment if they did.

29. **Sexual abuse by members of religious Orders was seldom brought to the attention of the Department of Education by religious authorities because of a culture of silence about the issue.**
When religious staff abused, the matter tended to be dealt with using internal disciplinary procedures and Canon Law. The Gardaí were not informed. On the rare occasions when the Department was informed, it colluded in the silence. There was a lack of transparency in how the matter of sexual abuse was dealt with between the Congregations, dioceses and the Department. Men with histories of sexual abuse when they were members of religious Orders continued their teaching careers as lay teachers in State schools.

30. **The Department of Education dealt inadequately with complaints about sexual abuse. These complaints were generally dismissed or ignored. A full investigation of the extent of the abuse should have been carried out in all cases.**
All such complaints should have been directed to the Gardai for investigation.

The Department, however, gave the impression that it had a function in relation to investigating allegations of abuse but actually failed to do so and delayed the involvement of the proper authority. The Department neglected to advise parents and complainants appropriately of the limitations of their role in respect of these complaints.

Neglect

31. **Poor standards of physical care were reported by most male and female complainants.**
Schools varied as to the standard of physical care provided to the children and while there was evidence from many complainants that conditions improved in the late 1960s, in general no school provided an adequate standard of care across all the categories.

32. **Children were frequently hungry and food was inadequate, inedible and badly prepared in many schools.**
Witnesses spoke of scavenging for food from waste bins and animal feed.

In boys' schools there was so little supervision at meal times that bullying was widespread and smaller, weaker boys were often deprived of food.

The Inspector found that malnourishment was a serious problem in schools run by nuns in the 1940s and, although improvements were made, the food provided in many of these schools continued to be meagre and basic.

33. **Witnesses recalled being cold because of inadequate clothing, particularly when engaged in outdoor activities.**

Clothing was a particular problem in boys' schools where children often worked for long hours outdoors on farms. In addition, boys were often left in their soiled and wet work clothes throughout the day and wore them for long periods.

Clothing was better in girls' schools and some individual Resident Managers made particular efforts in this regard but in general girls were obliged to wear inadequate ill-fitting clothes that were often threadbare and worn.

In all schools up until the 1960s clothes stigmatised the children as Industrial School residents.

34. **Accommodation was cold, spartan and bleak. Sanitary provision was primitive in most boys' schools and general hygiene facilities were poor.**

Children slept in large unheated dormitories with inadequate bedding, which was a particular problem for children with enuresis.

Sanitary protection for menstruation was generally inadequate for girls.

35. **The Cussen Report recommended in 1936 that Industrial School children should be integrated into the community and be educated in outside national schools. Until the late 1960s, this was not done in any of the boys' schools investigated and in only in a small number of girls' schools.**

36. **Where Industrial School children were educated in internal national schools, the standard was consistently poorer than that in outside schools.**

National school education was available to all children in the State and those in Industrial Schools were entitled to at least the same standard as that available in the country generally. Internal national schools were funded by a national school grant and teachers were paid in the same way as in ordinary national schools. The evidence was however that the standard of education in these schools was poor.

There was evidence particularly in girls' schools that children were removed from their classes in order to perform domestic chores or work in the institution during the school day. In general, Industrial School children did not receive the same standard of national school education as would have been available to them in the local community. This lack of educational opportunity condemned many of them to a life of low-paying jobs and was a commonly expressed loss among witnesses.

37. **Academic education was not seen as a priority for industrial school children.**

When discharged, boys were generally placed in manual or unskilled jobs and girls in positions as domestic servants. There were exceptions, and particularly in girls' schools in the later years, some girls received the opportunity of a secretarial or nursing qualification. Education usually ceased in 6th class, after which children were involved in industrial trades, farming and domestic work with very limited education thereafter. Even where religious Congregations operated secondary schools beside industrial schools, children from the Industrial Schools were very rarely given the opportunity of pursuing secondary school education.

38. **Industrial Schools were intended to provide basic industrial training to young people to enable them to take up positions of employment as young adults. In reality, the industrial training afforded by all schools was of a nature that served the needs of the institution rather than the needs of the child.**

This was a problem that had been pointed out by the Cussen Commission in 1936 and continued to be a feature of industrial training in these schools throughout the relevant period. Child labour on farms and in workshops was used to reduce the costs of running the Industrial Schools and in many cases to produce a profit. Clothing and footwear were often made on the premises and bakeries and laundries provided facilities to the school and in some cases to the general public. The cleaning and upkeep of girls' Industrial Schools was largely done by the girls themselves. Some of these chores were heavy and arduous and exacting standards were imposed that were difficult for young children to meet. In girls' schools also, older residents were expected to care for young children and babies on a 24-hour basis. Large nurseries were supervised and staffed by older residents with only minimal supervision by adults.

Emotional abuse

39. **A disturbing element of the evidence before the Commission was the level of emotional abuse that disadvantaged, neglected and abandoned children were subjected to generally by religious and lay staff in institutions.**

Witnesses spoke of being belittled and ridiculed on a daily basis. Humiliating practices such as underwear inspections and displaying soiled or wet sheets were conducted throughout the Industrial School system. Private matters such as bodily functions and personal hygiene were used as opportunities for degradation and humiliation. Personal and family denigration was widespread, particularly in girls' schools. There was constant criticism and verbal abuse and children were told they were worthless. The pervasiveness of emotional abuse of children in care throughout the relevant period points to damaging cultural attitudes of many who taught in and operated these schools.

40. **The system as managed by the Congregations made it difficult for individual religious who tried to respond to the emotional needs of the children in their care.**

Witnesses from the religious Congregations described the conflict they experienced in fulfilling their religious vows, whilst at the same time providing care and affection to children. Authoritarian management in all schools meant that staff members were afraid to question the practices of managers and disciplinarians.

41. **Witnessing abuse of co-residents, including seeing other children being beaten or hearing their cries, witnessing the humiliation of siblings and others and being forced to participate in beatings, had a powerful and distressing impact.**

Many witnesses spoke of being constantly fearful or terrified, which impeded their emotional development and impacted on every aspect of their life in the institution. The psychological damage caused by these experiences continued into adulthood for many witnesses.

42. **Separating siblings and restrictions on family contact were profoundly damaging for family relationships. Some children lost their sense of identity and kinship, which was never recovered.**

Sending children to isolated locations increased the sense of loss and made it almost impossible for family contact to be maintained. Management did not recognise the rights of children to have contact with family members and failed to acknowledge the value of family relationships.

43. **The Confidential Committee heard evidence in relation to 161 settings other than Industrial and Reformatory Schools, including primary and second-level schools, Children's Homes, foster care, hospitals and services for children with special needs, hostels, and other residential settings. The majority of witnesses reported abuse and neglect, in some instances up to the year 2000. Many common features emerged about failures of care and protection of children in all of these institutions and services.**
Witnesses reported severe physical abuse in primary schools, foster care, Children's Homes and other residential settings where those responsible neglected their duty of care to children.

The predatory nature of sexual abuse including the selection and grooming of socially disadvantaged and vulnerable children was a feature of the witness reports in relation to special needs services, Children's homes, hospitals and primary and second-level schools. Children with impairments of sight, hearing and learning were particularly vulnerable to sexual abuse.

Witnesses reported neglect of their education, health and aftercare in all residential settings and foster care. No priority was given to the special care needs of children who were placed away from their families.

Children in isolated foster care placements were abused in the absence of supervision by external authorities. They were placed with foster parents who had no training, support or supervision. The suitability of those selected as foster parents was repeatedly questioned by witnesses who were physically and sexually abused.

Many witnesses described losing their sense of family and identity when placed in out-of-home care, they reported that separation from siblings and deprivation of family contact was abusive and contributed to difficulties reintegrating with their family of origin when they left care. Witnesses reported emotional abuse in institutions, foster care and schools when they were deprived of affection, secure relationships and were exposed to personal denigration, fear and threats of harm.

When witnesses left care the failure to provide them with personal and family records contributed to disadvantage in later life. Many witnesses spent years searching for information to establish their identity.

The failure of authorities to inspect and supervise the care provided to children in hospitals and special needs services was noted as contributing to abuse which occurred in those facilities. The absence of structures for making complaints or investigating abuse allowed abuse to continue.

When opportunities were provided for children to disclose abuse they did so.

Witnesses reported that the power of the abuser, the culture of secrecy, isolation and the fear of physical punishment inhibited them in disclosing abuse.

Recommendations

1. Arising from the findings of its investigations and the conclusions that were reached, the Commission was required to make recommendations under two headings:

   (i) To alleviate or otherwise address the effects of the abuse on those who suffered

   (ii) To prevent where possible and reduce the incidence of abuse of children in institutions and to protect children from such abuse

(i) To alleviate or otherwise address the effects of the abuse on those who suffered

2. **A memorial should be erected.**

The following words of the special statement made by the Taoiseach in May 1999 should be inscribed on a memorial to victims of abuse in institutions as a permanent public acknowledgement of their experiences. It is important for the alleviation of the effects of childhood abuse that the State's formal recognition of the abuse that occurred and the suffering of the victims should be preserved in a permanent place:

> On behalf of the State and of all citizens of the State, the Government wishes to make a sincere and long overdue apology to the victims of childhood abuse for our collective failure to intervene, to detect their pain, to come to their rescue.

3. **The lessons of the past should be learned.**

For the State, it is important to admit that abuse of children occurred because of failures of systems and policy, of management and administration, as well as of senior personnel who were concerned with Industrial and Reformatory Schools. This admission is, however, the beginning of a process. Further steps require internal departmental analysis and understanding of how these failures came about so that steps can be taken to reduce the risk of repeating them.

The Congregations need to examine how their ideals became debased by systemic abuse. They must ask themselves how they came to tolerate breaches of their own rules and, when sexual and physical abuse was discovered, how they responded to it, and to those who perpetrated it. They must examine their attitude to neglect and emotional abuse and, more generally, how the interests of the institutions and the Congregations came to be placed ahead those of the children who were in their care.

An important aspect of this process of exploration, acceptance and understanding by the State and the Congregations is the acknowledgement of the fact that the system failed the children, not just that children were abused because occasional individual lapses occurred.

4. **Counselling and educational services should be available.**

Counselling and mental health services have a significant role in alleviating the effects of childhood abuse and its legacy on following generations. These services should continue to be provided to ex-residents and their families. Educational services to help alleviate the disadvantages experienced by children in care are also essential.

5. **Family tracing services should be continued.**

Family tracing services to assist individuals who were deprived of their family identities in the process of being placed in care should be continued. The right of access to personal documents and information must be recognised and afforded to ex-residents of institutions.

(ii) To prevent where possible and reduce the incidence of abuse of children in institutions and to protect children from such abuse

6. **Childcare policy should be child-centred. The needs of the child should be paramount.**
The overall policy of childcare should respect the rights and dignity of the child and have as its primary focus their safe care and welfare. Services should be tailored to the developmental, educational and health needs of the particular child. Adults entrusted with the care of children must prioritise the well-being and protection of those children above personal, professional or institutional loyalty.

7. **National childcare policy should be clearly articulated and reviewed on a regular basis.**
It is essential that the aims and objectives of national childcare policy and planning should be stated as clearly and simply as possible. The State and Congregations lost sight of the purpose for which the institutions were established, which was to provide children with a safe and secure environment and an opportunity of acquiring education and training. In the absence of an articulated, coherent policy, organisational interests became prioritised over those of the children in care. In order to prevent this happening again childcare services must have focused objectives that are centred on the needs of the child rather than the systems or organisations providing those services.

8. **A method of evaluating the extent to which services meet the aims and objectives of the national childcare policy should be devised.**
Evaluating the success or failure of childcare services in the context of a clearly articulated national childcare policy will ensure that the evolving needs of children will remain the focus of service providers.

9. **The provision of childcare services should be reviewed on a regular basis.**
Out-of-home care services should be reviewed on a regular basis with reference to best international practice and evidence-based research. This review should be the responsibility of the Department of Health and Children and should be co-ordinated to ensure that consistent standards are maintained nationally. The Department should also maintain a central database containing information relevant to childcare in the State while protecting anonymity. Included in such a database should be the social and demographic profile of children in care, their health and educational needs, the range of preventative services available and interventions used. In addition, there should be a record of what happens to children when they leave care in order to inform future policy and planning of services. A review of legislation, policies and programmes relating to children in care should be carried out at regular intervals.

10. **It is important that rules and regulations be enforced, breaches be reported and sanctions applied.**
The failures that occurred in all the schools cannot be explained by the absence of rules or any difficulty in interpreting what they meant. The problem lay in the implementation of the regulatory framework. The rules were ignored and treated as though they set some aspirational and unachievable standard that had no application to the particular circumstances of running the institution. Not only did the individual carers disregard the rules and precepts about punishment, but their superiors did not enforce the rules or impose any disciplinary measures for breaches. Neither did the Department of Education

11. **A culture of respecting and implementing rules and regulations and of observing codes of conduct should be developed.**
Managers and those supervising and inspecting the services must ensure regularly that standards are observed.

12. **Independent inspections are essential.**
All services for children should be subject to regular inspections in respect of all aspects of their care. The requirements of a system of inspection include the following:

- There is a sufficient number of inspectors.
- The inspectors must be independent.
- The inspectors should talk with and listen to the children.
- There should be objective national standards for inspection of all settings where children are placed.
- Unannounced inspection should take place.
- Complaints to an inspector should be recorded and followed up.
- Inspectors should have power to ensure that inadequate standards are addressed without delay.

13. **Management at all levels should be accountable for the quality of services and care.**
Performance should be assessed by the quality of care delivered. The manager of an institution should be responsible for:

- Making the best use of the available resources
- Vetting of staff and volunteers
- Ensuring that staff are well trained, matched to the nature of the work to be undertaken and progressively trained so as to be kept up to date
- Ensuring on-going supervision, support and advice for all staff
- Regularly reviewing the system to identify problem areas for both staff and children
- Ensuring rules and regulations are adhered to
- Establishing whether system failures caused or contributed to instances of abuse
- Putting procedures in place to enable staff and others to make complaints and raise matters of concern without fear of adverse consequences.

14. **Children in care should be able to communicate concerns without fear.**
Children in care are often isolated with their concerns, without an adult to whom they can talk. Children communicate best when they feel they have a protective figure in whom they can confide.

The Department of Health and Children must examine international best practice to establish the most appropriate method of giving effect to this recommendation.

15. **Childcare services depend on good communication.**
Every childcare facility depends for its efficient functioning on good communication between all the departments and agencies responsible. It requires more than meetings and case conferences. It should involve professionals and others communicating concerns and suspicions so that they can act in the best interests of the child. Overall responsibility for this process should rest with a designated official.

16. **Children in care need a consistent care figure.**
Continuity of care should be an objective wherever possible. Children in care should have a consistent professional figure with overall responsibility.

The supervising social worker should have a detailed care plan the implementation of which should be regularly reviewed, and there should be the power to direct that changes be made to ensure standards are met. The child, and where possible the family, should be involved in developing and reviewing the care plan.

17. **Children who have been in State care should have access to support services.**
Aftercare services should be provided to give young adults a support structure they can rely on. In a similar way to families, childcare services should continue contact with young people after they have left care as minors.

18. **Children who have been in childcare facilities are in a good position to identify failings and deficiencies in the system, and should be consulted.**
Continued contact makes it possible to evaluate whether the needs of children are being met and to identify positive and negative aspects of experience of care.

19. **Children in care should not, save in exceptional circumstances, be cut off from their families.**
Priority should be given to supporting ongoing contact with family members for the benefit of the child.

20. **The full personal records of children in care must be maintained.**
Reports, files and records essential to validate the child's identity and their social, family and educational history must be retained. These records need to be kept secure and up to date. Details should be kept of all children who go missing from care. The privacy of such records must be respected.

21. **'Children First: The National Guidelines for the Protection and Welfare of Children' should be uniformly and consistently implemented throughout the State in dealing with allegations of abuse.**