This chapter summarises witness reports given in evidence to the Confidential Committee in relation to 18 different facilities categorised under the general heading of Hospitals. Among the facilities reported to the Committee and categorised as hospitals for the purpose of this Report were general hospitals, specialist and rehabilitation hospitals, and county homes. The facilities reported in this section were funded to provide a service to the public and were managed by a variety of organisations including religious communities, boards of management and State bodies.

**Witnesses**

The Report refers to hospital admissions between 1935 and 1991. The 56-year period covers the date of earliest admission and latest discharge of witnesses who reported abuse in hospital settings. Seven (7) of the facilities were city based and 11 were in provincial and rural areas.

There were 33 reports of abuse made by 31 witnesses, 17 male and 14 female, in relation to the 18 hospitals or other facilities categorised by the Committee as hospitals. One witness reported abuse in three different hospitals. There were between two and seven reports in relation to four of the hospitals and the remaining 14 hospitals were each the subject of single reports.

Four (4) witnesses reported abuse in other settings in addition to hospitals, two reports were made in relation to Industrial Schools and one each in relation to a Children’s Home and another residential facility. The abuse details regarding those accounts are recorded in the relevant chapters of this Report.

**Social and demographic profile of witnesses**

Family of origin, place of birth and current residence details will be differentiated by gender when there are notable differences. Among the witnesses who reported abuse in hospitals, eight were born in Dublin and, of the remaining 22 witnesses, 21 were from 15 other counties in Ireland and one was born outside the State. All 31 witnesses reported that they came from two-parent households, although at the time of admission six witnesses reported that their parents were either widowed or had separated.

Witnesses reported their parents' occupational status as shown in Table 88:1

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1 The categorisation is based on Census 2002, Volume 6 Occupations, Appendix 2, Definitions – Labour Force. In two-parent households the father’s occupation was recorded and in other instances the occupational status of the sole parent was recorded, in so far as it was known.
### Table 88: Occupational Status of Witnesses’ Parents – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Occupational status</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional worker</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Managerial and technical</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Non-manual</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Skilled manual</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unskilled</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Unavailable</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>15</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.07 Information regarding parents’ occupational status was not reported, or available, in five instances.

16.08 Twenty four (24) of the 31 witnesses reported having ongoing contact with their parents and/or other family members during their time in hospital and when they were discharged. Four (4) other witnesses reported having little or no family contact following their admission and feeling abandoned by their parents in the process. Information regarding family contact was not available about the remaining three witnesses.

16.09 All 31 witnesses reported having siblings and 27 came from families of more than four children.

16.10 Six (6) witnesses reported having siblings who were also in out-of-home care. Five (5) of those witnesses reported that they and their siblings were admitted to out-of-home care in the context of parental death, illness or impoverished circumstances and neglect. They were admitted to Children’s Homes, Industrial Schools or county homes. Another witness reported having a sibling who was also in a long-term hospital placement for medical reasons.

16.11 At the time of their hearing most witnesses were aged between 40 and 59 years and three witnesses were aged under 40 years, as the following table indicates:

### Table 89: Age Range of Witnesses at Time of Hearing – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Age range</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29 years</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>30–39 years</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>40–49 years</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>50–59 years</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>60–69 years</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>70+ years</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>14</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.12 Twenty three (23) witnesses were living in Ireland at the time of their hearing and eight were resident in the UK.

**Circumstances of admission**

16.13 Witnesses reported being admitted to hospital in various circumstances for both brief and lengthy periods of time. Among the reasons stated for admission to these facilities were acute and chronic illness, physical disability, convalescence, and for social reasons such as parental abandonment and family crises caused by illness, death and marital separation.
Sixteen (16) witnesses reported being hospitalised for the treatment of illnesses and disabilities that necessitated lengthy admissions and that, in a number of instances, resulted in life-long health and mobility impairments.

Eight (8) of the 16 witnesses reported having serious injuries, illnesses and physical disabilities including spina bifida and polio, which required medical treatment not available to them at the time on an outpatient basis. Five (5) other witnesses who were hospitalised for the treatment of chronic conditions reported being diagnosed with tuberculosis and were in-patients for between one and 14 years. Three (3) witnesses reported that they were admitted to hospital as a result of a combination of illness/disability and what they believed was their family’s inability to care for them. Some admissions that were believed to have been initiated as family respite placements extended into long-term admissions due to the unavailability of out-patient facilities, especially in rural areas.

Eight (8) witnesses reported being hospitalised for the treatment of acute medical illnesses or injuries, including pleurisy, diphtheria, rheumatic fever, appendicitis and sports injuries. These witnesses had relatively brief admissions, of between a few days and several months’ duration.

A further six witnesses were admitted to hospital facilities because their respective families were reported to be unable to cope with their child’s illness or disability and/or associated parental responsibilities. In three instances witnesses reported being placed in county homes following the death of a parent while awaiting longer term residential placements. Two (2) of the witnesses were then transferred to Industrial Schools and one witness reported being retained in a county home until sent out to work at 14 years of age.

One witness reported that he was transferred to an adult psychiatric hospital from an Industrial School following an altercation with staff in the context of physical abuse.

The evidence presented by witnesses would indicate that the age of admission to these hospital facilities varied according to the reason for admission. Most admissions were at relatively young ages, with 18 of the 31 witnesses admitted to hospital facilities when they were aged five years or less, as shown in the following table:

<table>
<thead>
<tr>
<th>Age of first admission</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–5 years</td>
<td>9</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>6–10 years</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>11–15 years</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>16–17 years</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>14</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

Four (4) witnesses reported being admitted to hospitals at birth or in early infancy as a result of their physical disabilities and that they remained in residential facilities for the duration of their childhood and adolescence. Other witnesses reported that, as a result of their disability, they were unable to attend their local primary school when they reached school-going age, and were instead admitted to residential facilities.

The length of time the 31 witnesses reported being in out-of-home care varied between five days and 18 years. Fifteen (15) of the 31 witnesses reported spending five years or less in hospital for treatment of their particular illness or disability. Table 91 illustrates the range of time witnesses reported being hospitalised and in out-of-home care:
Table 91: Length of Stay in Out-of-Home Care – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Length of stay in care</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>2–5 years</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>6–10 years</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>10+ years</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>14</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.22 The average length of stay reported by witnesses in the hospital facilities was seven years for male witnesses and four and a half years for female witnesses. Eight (8) witnesses reported being abused during admissions of less than one year. There was a marked difference in both the average length of stay and type of abuse reported by male and female witnesses. A higher proportion of female witnesses reported abuse during brief hospital admissions and more male witnesses reported being abused in the course of lengthy admissions. These differences were reflected in the ages at which witnesses reported being discharged from out-of-home care, as shown below:

Table 92: Age when Discharged from Out-of-home Care – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Age when discharged</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;7 years</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>8–10 years</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>11–15 years</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>16+ years</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>14</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

Record of abuse

16.23 As already stated, 31 witnesses, 17 male and 14 female, made 33 reports of abuse in relation to 18 institutions referred to as hospitals. One witness reported being abused in three different hospitals in the course of consecutive admissions. The 33 reports covered a 56-year period and included all types of abuse defined by the Acts, specifically physical and sexual abuse, neglect and emotional abuse. A report of abuse made by a witness may either refer to a description of a single episode or to multiple experiences of being abused. In most, but not all, instances reports of abuse in hospitals refer to more than one episode of abuse and more than one type of abuse.

16.24 All four abuse types were reported with similar frequency as detailed below:

- Nineteen (19) witnesses reported physical abuse.
- Sixteen (16) witnesses reported neglect.
- Fifteen (15) witnesses reported emotional abuse.
- Fourteen (14) witnesses reported sexual abuse.

16.25 Sixteen (16) witnesses reported that abuse was a regular occurrence and was most frequently reported as a combination of abuse types, as outlined in Table 93:

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2 Section 1(1) as amended by section 3 of the 2005 Act.

CICA Report Vol. III Confidential Committee
Table 93: Abuse Types and Combinations – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Abuse types and combinations</th>
<th>Number of reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, neglect and emotional</td>
<td>9</td>
</tr>
<tr>
<td>Sexual</td>
<td>8</td>
</tr>
<tr>
<td>Physical and neglect</td>
<td>4</td>
</tr>
<tr>
<td>Physical, sexual, neglect and emotional</td>
<td>3</td>
</tr>
<tr>
<td>Physical and emotional</td>
<td>3</td>
</tr>
<tr>
<td>Neglect and emotional</td>
<td>2</td>
</tr>
<tr>
<td>Physical, sexual and emotional</td>
<td>1</td>
</tr>
<tr>
<td>Physical and sexual</td>
<td>1</td>
</tr>
<tr>
<td>Physical</td>
<td>1</td>
</tr>
<tr>
<td>Sexual and neglect</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.26 Twenty four (24) reports were of combinations of abuse, 21 of which included physical abuse. The most frequently reported combination of abuse was physical and emotional abuse and neglect, reported by nine witnesses. It is notable that eight reports were of sexual abuse alone. In those eight instances witnesses described their experience of being sexually abused as isolated events in the course of their hospital admission.

16.27 Fourteen (14) of the 18 hospital facilities reported to the Committee were each the subject of single reports. The other four hospitals were each the subject of between two and seven reports, totalling 19 reports.

**Physical abuse**

*The wilful, reckless or negligent infliction of physical injury on, or failure to prevent such injury to, the child.*

16.28 Reports of physical abuse included descriptions of incidents of physical abuse, non-accidental injury and lack of protection from such abuse. Accounts were heard of witnesses being hit, beaten with implements, and kicked. Accounts were also heard of witnesses being immersed in water, physically restrained and isolated.

16.29 There were 22 reports of physical abuse by 19 witnesses in relation to 10 hospital facilities, as follows:

- Four (4) hospital facilities were each the subject of two to four reports, totalling 16 reports.
- Six (6) hospital facilities were the subject of single reports.

16.30 Nine (9) reports related to witnesses discharged in the 1950s and five related to witnesses discharged in the 1970s. The remaining eight reports were related to discharges in the 1940s, 1960s and 1990s, in diminishing frequency.

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3 Section 1(1)(a).
Description of abuse

16.31 The most frequently reported form of physical abuse was being hit as punishment for perceived misdemeanours, examples of which included bed-wetting, talking, crying, and not knowing the answers to a question. Witnesses reported that physical abuse was also precipitated by refusing to demonstrate functional abilities for visiting experts and medical consultants, not eating the food provided, and not following staff instructions.

16.32 Witnesses reported that they were hit with sticks, canes, straps, scissors, hair and hand brushes. Witnesses also reported having their hair pulled, being punched, kicked, immersed in cold water and being subjected to painful treatment procedures with little care or consideration. They reported being force fed, left lying in wet beds or on bedpans for lengthy periods, and being made to kneel on the floor or stand with their arms raised for extended periods of time.

I would have been about 9 or 10, there was this ...named female nurse... and she used to go around with this plastic ...implement... hitting children for stupid things, such as not standing in a queue, not going to school, not being on time. You might be at physio ... (physiotherapy)... and not be able to get to your classroom on time.... She hit ... across the hand, across the head, across the back of the legs. Everybody would know about it. I seen children with marks on the backs of the legs, blood and everything. She was really evil. I got a belt one day with her hand and with her...implement.... I retaliated once. I hit her in the chest with my head and got a real walloping off the staff then.... The staff did not care what way you were treated....

16.33 Witnesses described being physically abused in their hospital beds, on the wards, in bathrooms, dining rooms, classrooms, treatment and consulting rooms, and other areas within the hospital environment.

16.34 The majority of witnesses who reported abuse in this section were bed-bound either because of the traditional practice of a hospital ward where patients were kept in bed, or because of the nature of their disability or illness. Immobile patients were described as especially vulnerable and dependant. Several witnesses reported being subjected to painful treatments and interventions while they were unable to move. A witness described having partially healed cold sores pulled repeatedly from her lips while she was restrained in bed. Another witness reported that the Sister in charge dropped him to the ground as a punishment:

I remember one morning ... I was about 5 and I was sat up in the bed ... and I heard a voice behind and there’s a very tall nun looking down on me and she’s not pleased, I can tell by her face. She said I’d offended God, she called me a cripple. I remember it’s the first time I was ever called a cripple, ... She said before I was fit to meet him ... (God)... again, I’d have to be broken and she just picked me up out of the bed and she threw me down onto the ground ...distressed.... She’d just kick the shit out of me, picked me up and punched and beat me. That was not the first time ... (to be beaten)...., but it was the first time I was conscious that this is serious. ... After that I kept very, very quiet ... invisible ... where you think if you don’t speak you’re not going to get beaten, if you’re quiet there’s no excuse to beat you.

16.35 Other witnesses who were subjected to routine and painful physical interventions including injections, joint manipulation and surgery, reported being punished if they resisted or objected to the treatments. Being unable to move independently created particular difficulties in these circumstances.

I couldn’t run away, but I could hide under the bed in the corner, where they couldn’t get at me. They used to have to beat me out with a stick.
In all the time there I never remember getting a painkiller, the nuns used have this thing about pain where they’d believe you could be redeemed through pain. ... I remember a lot of pain, you didn’t complain because you knew you weren’t going to get anything for it, you’d grin and bear it, that’s the way it was.

16.36 Witnesses who were physically disabled or who had restricted mobility described being roughly treated by staff, causing injury in two instances. One witness described a member of the hospital care staff throwing her from one bed onto another in anger, which resulted in her falling and cutting her head. Another witness reported that a staff member pushed a trolley at her that knocked her over and caused an injury to her head that required medical attention. On both occasions the incidents were reported to staff in authority as ‘accidents’ within hearing of the witnesses.

16.37 Witnesses reported being punished for bed-wetting by having wet sheets draped over their heads, being left lying in wet sheets for long periods, and left sitting on bedpans, they believed, to avoid having to change wet or soiled sheets. Two (2) witnesses reported being forced to kneel or sit partially clothed against a wall with their arms extended ‘for hours’ as a punishment for bed-wetting. Another witness reported being smacked on his bared bottom in front of adult male patients on the ward where he was the only child.

All the kids were frightened of calling on the nurses...we were not allowed out of bed on our own, we couldn’t put a foot out of bed...there were terrible punishments, if you wee’d ... (urinated)... the bed, they made you remove the jacket of your pyjamas and they made you kneel against this wall, supplicate against this white clinical wall with your arms in the air until they decided it was time to go back to bed. If you defecated you lost your top and bottom and you’d be naked, kneeling against this wall ... with your hands above your head.

16.38 Five (5) witnesses reported being physically restrained by staff. Two (2) of those witnesses described being forcibly medicated while restrained and another witness described being tied to the rail of the hospital bed to curtail any movement. The other three witnesses reported being locked in cupboards or confined spaces overnight. Witnesses reported being restrained in these ways for reasons such as refusing to co-operate with a treatment procedure, for retaliating to a physical assault by staff or for indiscipline.

16.39 Three (3) witnesses reported being physically abused and beaten by older co-patients whom staff entrusted with the task of ‘minding’ younger patients on the ward in their absence. Witnesses stated that the older patients regarded this as an opportunity to hit them without fear of reproach. One witness reported being ‘terrorised’ by an older patient whom he believed the staff were unable to control on the ward and at times had to restrain. The same witness reported being abused and threatened by another co-patient in the absence of adequate supervision.

Reported abusers

16.40 Witnesses reported 23 individuals as physically abusive, 10 of whom were named female staff members. Six (6) of the named physical abusers were identified as lay nurses and four as religious Sisters who were believed to be nurses. One religious Sister was identified by name as physically abusive by four witnesses and a female lay nurse was similarly identified by two witnesses. The other eight named female staff were the subject of single witness reports.

16.41 There were another nine accounts of abuse by unnamed religious and lay care staff, including nursing staff, and three reports of older patients physically abusing witnesses. There were three accounts of groups of care staff being abusive without an individual perpetrator being identified.
Two (2) reports of unnamed abusers refer to male nursing staff and co-patients. One witness reported being physically abused by the husband of a lay care worker to whom he had been sent to work from the hospital. It is possible that there is some overlap between those named and not named as abusers.

**Sexual abuse**

*The use of the child by a person for sexual arousal or sexual gratification of that person or another person.*

16.42 Witness reports of sexual abuse given in evidence to the Committee referred to both contact and non-contact abuse, with the majority referring to contact sexual abuse, predominantly rape. Reports of sexual abuse from male and female witnesses in relation to hospital facilities were noteworthy as most often single or infrequent incidents.

16.43 Fourteen (14) witnesses reported being sexually abused, eight of whom reported sexual abuse as the only category of abuse experienced. A further six witnesses reported being sexually abused in combination with other forms of abuse. The 14 reports of sexual abuse refer to 12 different hospital facilities, as follows:

- Two (2) hospitals were each the subject of two reports, totalling four reports.
- Ten (10) hospitals were each the subject of single reports.

16.44 There were five reports of sexual abuse by witnesses discharged in the 1960s, and two each in relation to the 1940s, 1950s, 1970s and 1980s. There was one report in relation to the 1990s.

**Description of abuse**

16.45 Witnesses described being subjected to contact sexual abuse including fondling, digital penetration and rape. Female witnesses also reported being subjected to painful internal examinations and male witnesses reported being fondled and masturbated under the pretext of medical examinations in hospital settings.

16.46 Witnesses reported that they were sexually abused in their hospital beds, in examination rooms and cubicles, doctors' offices, bathrooms, and toilets. Incidents of sexual abuse were described as unobserved by others and generally as occurring in discrete and isolated locations.

16.47 Six (6) of the reports of sexual abuse were single incidents, including four accounts of rape or penetrative assault. The witnesses described being confronted in their beds by men they did not recognise who motioned to them to keep quiet while they digitally penetrated and/or fondled their breasts or genitals.

*I was awakened by this guy and he was half into the bed, he was at me down there... (genital area) ...I tried to move up in the bed and he punched me pretty hard around the body. I kept quiet then. I don’t know how long he was there...I don’t know who it was, there was no word spoken at all...distressed ...I found that the worst of all, I can see him looking at me. I thought he had a short white coat on...I couldn’t be sure...any doctor who ever came in there... (to the hospital)... had a longish coat... I was wishing I could meet him, and if I had a shotgun..."

16.48 Four (4) witnesses described being inappropriately fondled and penetrated, both digitally and by objects, in situations where there was inadequate supervision. The witnesses reported being isolated by older patients who abused them. One witness reported being forced into a toilet cubicle by an older boy on three occasions where he was inappropriately fondled and analy

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1 Section 1(1)(b).
penetrated with an object. A female witness admitted to hospital with an acute illness at six years of age reported being fondled and abused on several occasions by an older boy while another male patient kept watch. The witness reported that the ward was generally well supervised and she was well cared for by the staff. She had no family contact during her hospital admission. Another witness reported being sexually abused by fondling by an adult male patient in circumstances where the witness was not adequately supervised.

**Reported abusers**

16.49 There were three male staff members identified by name as sexually abusive by witnesses, two of whom were reported to have been medical doctors, and a third was described as a hospital orderly.

> He ... (named doctor) ... proceeded to open my trousers and pulled me pants down to me knees and started to masturbate me and ask me questions, “when did I last have sex with a girl?” ... And then he asked me to stand up and turned me around and ... witness described anal penetration....

16.50 Six (6) witnesses reported being sexually abused by unnamed male and female nursing, care and ancillary staff. As previously stated another witness reported being raped in a hospital ward as a young child by an unidentified man whom he believed was the priest who provided a pastoral service to the hospital.

> I had been sexually abused in that home ... (named hospital).... My memory is of somebody taking me by the hand.... I can remember the sound of the cassock that they wear whenever they are walking, I remember the swishing that it makes.... They would have been big and strong, maybe like a father figure.... He took me into a room where the curtains were pulled, there was a light shining through the curtain.... The name of the person, I wouldn’t have a clue.

16.51 In one instance a witness reported being raped and inappropriately fondled by an unidentified male wearing a white coat. Another male witness reported being inappropriately fondled and subject to inappropriate attention including sexually explicit talk by a female nurse.

16.52 Four (4) other witnesses, two male and two female, reported being fondled and/or anally penetrated with objects by unnamed older co-patients, both male and female.

16.53 Two (2) female witnesses reported being subjected to internal examinations by female lay and religious staff when they were found talking or interacting with male co-patients. One witness reported that she was restrained by two nuns while another nun conducted a painful internal examination on her for reasons that were not explained to her at the time. The second witness reported being abused in the same manner on three separate occasions by female lay staff. A third female witness reported being fondled, internally examined and digitally penetrated by an unnamed medical doctor while she was in hospital for treatment of a viral illness.

**Neglect**

Failure to care for 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 or her behaviour or welfare.\(^5\)

16.54 The following section refers to the evidence of neglect provided by witnesses to the Committee including neglect of their education, inadequate provision of food, poor hygiene and poor supervision. A further aspect of neglect reported by witnesses was the placement of children

\(^5\) Section 1(1)(c) as amended by section 3 of the 2005 Act.
and juveniles in treatment facilities for adults, including a psychiatric hospital, without provision for their developmental and educational needs.

16.55 Seventeen (17) witnesses made 19 reports of neglect. One witness made reports of neglect in relation to three hospitals. The reports related to nine hospital facilities, as follows:

- Four (4) hospital facilities were each the subject of two to four reports, totalling 14 reports.
- Five (5) hospital facilities were each the subject of single reports.

16.56 Nine (9) witnesses reported being physically and sexually abused in the absence of adequate supervision, for example being a child left in a ward of adult patients and being left unobserved and unsupervised in hospital rooms and cubicles. One witness was sent out to work for local farmers as a day labourer from the county home where he was placed as a young child. He reported being both physically abused and neglected in these work placements where nobody ever called to check on his welfare.

16.57 Five (5) of the eight hospitals about which the Committee heard reports of neglect were adult hospitals or county homes to which witnesses were admitted as children, and where, as one witness remarked: ‘there was no one there to protect me, no one to look after me’. They reported that they had no contact with other children and no provision was made to address their childhood fears and anxieties. One witness gave the following account of his transfer to a psychiatric hospital when he was 14 years old:

*The nuns sent me into a mental home for about 2 years. ... I had a fight with one of the lads ... (co-residents)..., they thought I was a bit of a bully. ... Sr ...X... said “you are going away for a bit of a holiday somewhere” ... I landed up in ...named psychiatric hospital... She ... (Sr X)... was gone out the door and I couldn’t get out the door and the windows was all locked. ... I was the youngest patient in the hospital, locked in, I was there for about 2 years. It was worse than hell. They gave me shock treatment and drugged me up to the last. Three or 4 of them would tie me down when they were trying to give me injections. They locked me into a padded cell for about a day and night ... when I tried to put my hands through a window.*

16.58 Nine (9) witnesses reported that the food in the hospitals where they were patients was ‘appalling’, ‘disgusting’, ‘terrible’ and that there was ‘very little of it’. One witness described being nauseated by the food and was force fed when he refused to eat it. Another witness reported being made to eat his food from the floor if he spat it out.

16.59 Six (6) witnesses reported that they received little or no education during their time in hospital; one witness believed that due to his physical infirmity he was regarded as intellectually disabled and was consequently not allowed to proceed to second-level education. Another witness was completely bed-ridden for three years during which time she stated she received no schooling or intellectual stimulation of any kind. A witness from one hospital commented that all the children were treated as if they had a ‘mental disability’, and there was no proper assessment of individual needs.

16.60 Five (5) witnesses reported that they wet and soiled their beds, dressings and clothing because their toileting needs were not properly attended to by staff and four witnesses reported that because they wet their beds their personal hygiene was neglected; they were left in wet beds for long periods and not assisted to the toilet when required.

*There’s little things, that for a child they’d be a big thing, but for an adult maybe not, like wanting to go to the toilet and they ... (lay staff)... not listening to you. I’d called a couple*
of times and they just ignored you and would be giving out to you ... and then I’d have an accident in the cot and they’d beat you.

**Emotional abuse**

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 or her behaviour or welfare.\(^6\)

16.61 This section refers to witness evidence of emotional abuse including; lack of affection and approval, deprivation of family contact and personal denigration which had an effect on witnesses social, emotional and physical functioning and development.

**Description of emotional abuse**

16.62 The forms of emotional abuse reported included; exposure to frightening situations, lack of affection, criticism, humiliation, deprivation of family contact, witnessing the abuse of others, and the failure to provide for their emotional needs as children, particularly while in adult hospital facilities. Loss of identity and lack of safety and protection were other components of the emotional abuse reported by witnesses:

> It’s something you won’t forget, them iron-bar cots... the little one beside me, she was crying, God love us we used put our hands out between the bars and hold her hand for comfort, you know... I never remember any kindness, never heard my name.

> I didn’t know what affection was, anyone to put their arm around you, you’d no support....

16.63 Seventeen (17) witnesses made 18 reports of emotional abuse. One witness reported being emotionally abused in two different hospital facilities. The 18 reports referred to nine hospital facilities, as follows:

- Five (5) hospital facilities were each the subject of two to four reports, totalling 14 reports.
- Four (4) hospital facilities were each the subject of single reports.

**Exposure to fearful situations**

16.64 The anticipatory fear experienced by witnesses in relation to medical procedures was one of the most frequently reported abuses in this category. Several witnesses emphasised the fear associated with waiting for the day when the treating doctor would come. They recalled a lack of information and reassurance provided by nursing and other staff regarding their painful treatments.

> I couldn’t understand why people could send you different places and you don’t know what they’re like. ... Nobody told me nothing. ... I had a friend who told me he had to go to hospital himself when he broke his leg ... he was a soccer man. ... He explained to me that he had to go to get his leg fixed up ... (similar medical treatment as witness)..., but nobody else told me anything. ... People used run me life for me, used tell me what to do and where to go.

16.65 Many witnesses commented on the frightening reality of being children in a hospital, particularly those who reported being placed in county homes or those who were on wards shared with adult patients. They described observing the pain and, at times, death of other patients without

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\(^6\) Section 1(1)(d) as amended by section 3 of the 2005 Act.
any acknowledgement by staff of the distress it may cause them, as recalled in the following three witness accounts:

They ... (co-patients)... were put into beds with old men in the county home, we all shared a big dormitory, old men, boys, all. The old men went in there to die. There wasn’t a week or a day when someone didn’t die. They came in there to die.

The ward that we would have been in you would have had geriatrics, Downs Syndrome people and children, everyone would have been in these big wards ... no segregation or anything. People would have died roaring absolutely roaring during the night, they would have been dead in the morning and taken out then

Then you’d hear the other kids, you’d hear them crying and you’re thinking “what’s happening?”...The thing is you’re a cripple and why should a cripple have to go through that?

Isolation was a form of punishment reported by six witnesses and included being locked in a darkened room, a linen cupboard, an outside shed, being ignored, not spoken to, put to bed early, and excluded from recreational activities and the company of co-patients. Witnesses described such punishments:

There was a change of Reverend Mother ...named religious staff .... She came in with a whipping attitude.... I did not want to be an exhibition to someone who was coming in. She came in this afternoon with Health Board people and she says “now show these people what you can do” ...[witness instructed to demonstrate unusual physical dexterity].... I said “no, I don’t want to do it”.... That evening I was summoned to the convent, she came in and she’d tell the nurse to leave, she ridiculed me then for not doing this exhibition. I was banned from everything. ... I wasn’t allowed out anywhere, I had to come straight back to my ward from school, if there was homework I was to do it and then be put to bed, no telly ... the curtains were to be pulled around the bed ... they couldn’t turn off the telly for the other lads. I wasn’t to play with anybody or go around with friends, nothing for 2 weeks.

If you were sick in school and got sent back up to the ward ... you’d have hell to pay. .... They ... (lay staff)...were like the priests, they’d give you penance ... (for being sent back to the ward).... Like one day she ...(lay ancillary worker)... locked me in the ...[linen]... room and she wouldn’t let me out, locked me in ... and I didn’t get out until the following morning, left me there in the dark and I was petrified. ... One of the orderlies came down in the morning to get the linen to make the boys’ beds and he said “Jesus, Mary and Joseph, what are you doing in there?” I was sitting in there on a pillow and she’d taken away my chair ... (wheelchair)....

Witnesses also reported being punished for behaviours over which they had no control. For example witnesses who were immobile reported being punished for bed-wetting.

Witnesses who were placed in adult hospital wards, where they were the only child among a large number of elderly patients, also reported that experience as frightening. Witnesses commented that no allowance was made for the fact that they were children, there were no toys to play with and there was no acknowledgement of childhood fears and anxieties. Several witnesses described being treated as objects of amusement by staff, without respect for their feelings: They’d... (lay staff)... make fun of you because of how you spoke and they’d call you names to do with where you’re from. I was from...X... and they’d call you...X..., it sounds funny but it wasn’t funny to a child.
You never had the confidence to ask them what are they talking about...it just went over your head, what they said, you weren’t allowed to speak, you just had to go and find out.

16.69 A witness who was placed in an adult psychiatric hospital at 14 years of age described being placed in a locked ward with disturbed and institutionalised adults, and told the Committee: ‘I saw things and things happened that I can never talk about.’

16.70 Witnessing co-patients being beaten, force-fed and humiliated was reported by five witnesses as a frightening experience.

There was a nun called Sr ...X ... she was the worst, most violent, most terrifying person I have come across in my life. ... She had a number of sticks of different shapes and sizes. ... (One day) ... when she called in a lad to her room ... she didn’t close the door and I just remember seeing him ...(co-patient)... get a crack across the side of the head and he didn’t fall backwards and he just slumped like a rag doll, unconscious, and I just knew that one day I’d have to go in there.

16.71 Two (2) other witnesses commented on the fact that they believed they were in hospital because they were going to die, although nobody spoke to them directly about this or provided any reassurance to allay their childhood anxieties.

**Personal denigration and humiliation**

16.72 Witnesses spoke about the indignity they experienced at the hands of staff, especially in relation to personal hygiene and toileting.

I used to go home for the summer and used to come back for the head shaving and the sheep dipping ... for lice. ... I suppose we weren’t as health conscious then as we are now. The bus used to collect us in the afternoon and drop us back to ...(named hospital)... and a male orderly that was on would be there, there was no “welcome back” or greeting or anything, just fuck them all in the bath and the disinfectant piled in and you’d be brought out and your head shaven completely. ... The staff didn’t care what way you were treated, every kid went through it.

> When we didn’t have wheelchairs we had to crawl up the steps on our knees, to go to the toilet out in the yard, and in the wintertime that is terrible when you’re not able to walk. ... But they treated us any way they liked, that was their idea, we had to do what they wanted, not what you wanted yourself.

16.73 One female witness reported being prevented from using her wheelchair to go the bathroom by herself, although she was capable of managing the task independently. The witness commented that, instead, she was ‘*manhandled*’, in and out of the toilet. Similarly, she reported not being allowed to feed or dress herself as she was considered too slow. Another witness described the way in which toileting was managed on the ward of a hospital where children were bed-bound but not immobile:

> They ... (staff)... hated to be disturbed at night.... If one wanted to go the bathroom we defecated or wee’d ... (urinated)... into our face flannels and we’d all rush to the loo in the morning to get rid of it.... Scrubbing and scrubbing the face flannels.... The smell of it was appalling.

16.74 Three (3) male witnesses reported being bed-bound and having to pass a urine bottle around from one to the other and being punished if it was dropped.
There was this pee jar... (urine bottle)... it was passed from bed to bed between the lads. ... This morning I dropped it and she ... (Sr X)... came around with the stick.... I got 24 slaps on the hand, she couldn't hold my hand in front, to hit me on the hand in front ...(due to disability)... and what did she do but she pulled the hand behind and hit me like that... distressed... I got 24 slaps.

16.75 Other witnesses reported being reluctant to request assistance from certain staff who complained when asked to take them to the toilet. The witnesses reported they were subsequently punished for wetting or soiling themselves. One witness who wet her bed was put outside at night to await the ‘special ghost train that comes to take children who wet their bed’. Another witness gave the following account of being punished because his physical disability prevented him from being able to perform certain functions:

The abuse was unbelievable, Jaysus, like, the beatings for no reason. I was beat for being unable to tie my shoes.... This particular nun... (distressed) ... was most abusive, it was one of them ...(wooden stick)... she had.... I could not put down my hand...
Witness described particular physical disability....They beat me the whole day the day of the Communion because I could not put my hand down, for the photograph for my mother.... You were afraid of your livin’ daylights.

16.76 Tensions between staff members were described as, at times, influencing how patients were treated. A witness reported overhearing an argument about her admission to the ward. She was aware that certain staff objected to her admission and she believed she was treated harshly as a result. Other witnesses reported overhearing staff discussing their personal attributes and medical conditions as if they were not there, without any direct discussion with the witnesses themselves.

They used have a discussion when they were bathing me, on my head, the size of me head and I remember them saying “this one has a very small head, I wonder will she be alright”. I remember thinking “what am I going to do about my small head?”...

Deprivation of family contact

16.77 Many witnesses were admitted to hospitals that were located long distances from their family home, and as a result family contact was unavoidably disrupted. Those who had lengthy admissions frequently reported feeling alienated from their family as a result.

I was in ...X... hospital from birth. I was born with a disability called...named condition.... I spent all my life in and out of institutions. ... I had a lot of operations, I was going for experimentation because they didn’t know a lot about it ... (named condition).... I was very little at home, they sent me home once for a holiday but I had to come back because I didn’t know what home was. My mother would visit about once a fortnight, but I knew very little about brothers or sisters.

16.78 Limited access to transport and telephones at the time contributed to the witnesses’ sense of isolation. The hospitals’ rules regarding visiting arrangements were described as an additional deterrent to family contact in these circumstances.

16.79 One witness described her mother regularly making a long journey by bus to visit her and on each occasion being obliged to wait outside for several hours after the official visiting time was over, until the return bus arrived. On one occasion when the witness’s mother could not visit, her sisters made the journey instead. They were not allowed to visit the witness and had to wait outside the hospital until their transport arrived at the end of the day. Another witness described her parents waving to her through a window when they arrived outside the regular visiting hours and were denied admission to see her.
Eight (8) witnesses reported that their lengthy admissions to hospitals or county homes were in the context of social or family difficulties, combined in most instances with specific health problems.

_I hope to God that anyone, ... never has to go to a place like that anymore ... you see you don't know what places are like when you don't know nothing about them, when you are just landed in and they ...(family members)... say “I have to leave you here now and I'll be up ...(to visit)... and I'll write and I'll ring you and see what happens”; and there’s me left sitting there thinking “what’s next?”_

Marital separation, illness and family disharmony were described as factors that contributed to a number of protracted hospital admissions. Six (6) of the witnesses reported having little or no subsequent contact with their parents or other family members. They reported that staff told them that they were in hospital because they were not wanted or because their parents could not look after them.

Letters, food parcels and presents from family members were reported to have been periodically retained by staff in some hospitals. A witness reported that food and toys she received from home were often taken by staff members who either kept them or gave them to other patients. Another witness reported being teased by care staff who openly consumed the sweets and other food she had been given by visitors.

**Knowledge of abuse**

Evidence was given of witnesses disclosing details of abuse to parents, relatives, care staff, and other professionals both within and outside the institutions. The investigation and outcome of abuse disclosures varied. Witnesses also commented that the public nature of certain aspects of the abuse they experienced made awareness unavoidable. They reported being abused in front of both other patients and staff members. A number of witnesses also remarked that the manner in which they were treated by staff was seen by many who visited the hospitals. Three (3) witnesses reported attending secondary schools in the local community where teachers were supportive and were believed to be aware of the deprivations and abuse the witnesses experienced in the hospital facilities where they resided.

**Abuse observed by others**

Twenty (20) witnesses reported that their abuse was directly observed by others during their admission, mainly by other patients and nursing and care staff. Two (2) witnesses reported that physical abuse of patients was witnessed by a doctor on one occasion and by various staff members on an ongoing basis in another facility. One witness described the look of shock on a visiting doctor’s face when he walked into a ward to see a patient being hit by a staff member. A witness reported that staff members attempted to compensate for the charge nurse’s harsh treatment of patients by being discreetly kind afterwards.

As previously mentioned the public nature of daily routines on a hospital ward where patients were confined to bed resulted in many witnesses being aware of abuse through direct observation. Witnesses believed that staff were similarly aware of what occurred.

**Disclosing abuse**

A number of witnesses commented that there was nobody they could talk to about the abuse they experienced. Some witnesses had no visitors and others remarked that there was no opportunity to talk privately when visitors did come. Witnesses with communication difficulties were particularly disadvantaged in relation to disclosing the abuse they were experiencing at the
time. Witnesses also commented on the fact that they did not understand what was happening to them and were afraid to talk to anyone about it:

- *I kind of know why I didn’t tell my mother what was going on, because I didn’t know what was right and what was wrong, so if I’d have told my mother she’d have gone mad.*

- *I used hear the nun saying “are you going to tell your mammy, are you going to tell your mammy?”...then it clicked, I said to myself that if I tell my mother then I’ll get another hiding.*

- *I couldn’t tell my parents ... (about sexual abuse) ...you just done what you were told. There was very little communication ... I didn’t know what the hell was going on, I thought it was all medical and you’d be thinking what were they at?*

16.87 Ten (10) witnesses reported telling someone about the abuse they experienced. Seven (7) of the reported disclosures were to parents or relatives and three were made to external professionals, including social workers, gardaí and a school counsellor. A number of other witnesses reported that they disclosed the abuse they had experienced for the first time when they attended the Commission.

*It is so important to tell someone about my experience...about what happened to me in hospital. The only time I ever talked about it before was to my wife... (recently)...not all the details. I wanted to tell someone, I didn’t know who to tell. I was going to tell the guard... (gardai)..., but that would upset all my family...I dearly wanted to tell someone, in case I passed away and it would never be told.*

**Outcome of disclosure**

16.88 Seven (7) witnesses reported that they were believed by those to whom they disclosed their abuse, including staff, other professionals and family members. In six instances the witnesses received positive responses to their abuse disclosures including the dismissal of an abusive staff member. In two instances, witnesses’ subsequent reports to the gardaí were stated to be have been investigated without any charges being made against the reported abusers.

16.89 One witness reported that staff members both within the hospital and through external services defended him in disputes with the religious Sister in charge. They attempted to protect him from abuse by her and complained to the higher authorities about the mistreatment to which he was subjected. The witness understood that staff members were initially threatened with dismissal for taking this stance on his behalf. He was subsequently transferred to a more supportive environment with the assistance of professionals external to the hospital.

16.90 Another witness told a relative that he was being beaten. When a complaint was made to the religious Sister in charge about the witness’s treatment the relative was sent a written request to stop visiting, which he ignored. The witness commented that he subsequently received better treatment, especially when he had visitors.

*It was worse for others, I had ...relative... who visited me, they... (relatives)... took me out and I told them.... Relatives... confronted staff ... to an extent it made a difference, I was left alone for the day they knew ...relative... was coming. Sr ...X....wrote to my mother to stop... relative... coming to visit me.*

16.91 Two (2) witnesses told their parents about isolated experiences of being sexually abused in the course of brief admissions. They reported their parents believed them and advised on how to
protect themselves from further abuse; the witnesses were not aware of further action being taken.

16.92 Two (2) other witnesses who reported that their disclosures were not believed commented that their parents were unable to accept that sexual or physical abuse would occur in a place such as a hospital, where people were being looked after. Another witness reported being punished when she told a member of staff that she was being physically abused by another staff member.

Current circumstances

16.93 This section summarises the information provided by witnesses during their hearings regarding their adult lives. It contains information about relationships, parenting, employment, general health, and the continued effect of childhood abuse on their adult lives, including some unavoidable overlap with the details of four witnesses who reported abuse in other institutions.

Relationships

16.94 Fifteen (15) witnesses reported having happy marital and personal relationships, including three witnesses who are now widowed. Six (6) witnesses were in unhappy relationships, two of which were characterised by violence. Ten (10) witnesses reported that they have been unable to establish or maintain an intimate relationship.

16.95 Thirteen (13) witnesses returned to live with their parents when they were discharged, most of whom had been in hospital for relatively brief periods for the treatment of acute medical conditions. Witnesses who spent lengthy periods of time in hospital reported having difficulty adjusting to life at home or in the community following their discharge. Parents and siblings were described as strangers by a number of witnesses who had spent their entire childhood in hospital.

16.96 Seven (7) witnesses reported that they were discharged from hospital to live with extended family members who had maintained contact with them throughout their admission. They reported that their relatives kept in contact with them in the absence of parental contact due to death, illness or abandonment.

16.97 Eight (8) witnesses reported that following their discharge from the hospital setting they continued to live in some form of institutional or supported accommodation as adults. The witnesses all reported that they have been unable to live independently or sustain formal paid employment. The following table outlines the witnesses’ relationship status at the time of their hearing:

Table 94: Status of Witnesses’ Relationships at the Time of Hearing 2000-2006 – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Relationship status</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Co-habiting</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>14</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

CICA Report Vol. III Confidential Committee
Parenting

16.98 Nineteen (19) witnesses reported having children and for the most part described their parenting experiences as happy. The witnesses had between one and seven children. Two (2) witnesses reported that their children were raised by their partners and that they have not maintained close contact with them.

Occupational and employment status

16.99 Fourteen (14) witnesses reported having a stable work record with regular employment in a variety of occupations including nursing, teaching, management, shop and factory work, and skilled trades. Five (5) witnesses reported being actively involved in the disability sector. Nine (9) other witnesses reported having erratic work histories as unskilled and casual workers. Others who had been in hospital for long periods of their childhood commented that the lack of formal education, training and preparation for independent living made it initially difficult for them to find employment or to progress beyond unskilled or casual work.

I had no education, my work wouldn’t involve money, I wouldn’t be able to make up money or fill books, so all my work was on a building site... with the shovel and pick.

My first job, I felt so stupid... this woman said to me “what time is it?” and I said “I haven’t got my glasses with me”...so she said “how can you do your stitching then?”...she knew I couldn’t tell the time and she helped... (taught)... me.

16.100 Table 95 shows the witnesses’ occupational status as reported at the time of their hearing:

Table 95: Witnesses’ Occupational Status at Time of Hearing – Male and Female

<table>
<thead>
<tr>
<th>Occupational status</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unskilled</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Non-manual</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Managerial and technical</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Professional worker</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Skilled manual</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Unavailable</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>14</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.101 Seven (7) witnesses categorised as ‘Other’ in the above table reported that their disabilities and personal circumstances have precluded them from formal employment. There was no information available regarding one witness’s occupational status.

Accommodation

16.102 Most witnesses lived independently and had stable housing arrangements. Fifteen (15) witnesses owned their own homes and another six witnesses were living in local authority housing. Five (5) witnesses were living in supported accommodation facilities such as sheltered housing for people with disabilities and facilities run by government and non-government agencies. A further three witnesses described their living arrangements and other aspects of

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7 The categorisation is based on Census 2002, Volume 6 Occupations, Appendix 2, Definitions – Labour Force. In two-parent households the father’s occupation was recorded and in other instances the occupational status of the sole parent was recorded, in so far as it was known.
their personal lives as uncertain and that they relied on the support and assistance of community agencies. There was no detailed information available for two witnesses.

**Health**

16.103 The health status of witnesses who reported abuse in hospital facilities reflected the fact that many were initially admitted to hospitals as a result of serious illness or significant disability. Information regarding health was provided by witnesses both directly and in the course of describing their current life circumstances. For the purpose of writing this Report the Committee categorised the witnesses’ physical and mental health status as good, reasonable or poor based on the information provided about past and current health history. Table 96 illustrates the physical health status of witnesses at the time of their hearing:

<table>
<thead>
<tr>
<th>Physical health status</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Reasonable</td>
<td>12</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Poor</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>14</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.104 Seven (7) witnesses described their current physical health as good and reported no particular concerns. They reported making good recoveries from tuberculosis or other illnesses for which they had been hospitalised as children.

16.105 Nineteen (19) witnesses described having reasonable physical health. They reported current physical health problems that were age related and/or the manageable consequences of their particular medical condition.

*I’m on an invalidity pension, it seems when you have my complaint it can affect a lot of things so I have to see a specialist a couple of times a year.

* * *

*I had a discharge in me ear, all that banging around the head and pulling your hair gave me a mastoid, I’m sure it did...all the smacking around and the noise over not speaking up...*

16.106 Six (6) of the 19 witnesses were wheelchair dependant or required mobility aids. Six (6) witnesses reported experiencing ongoing health difficulties that required surgery and other treatments. They reported that their mobility was restricted and that their lives were affected on a daily basis by the ongoing effects of their childhood illnesses and congenital conditions.

16.107 Five (5) witnesses reported having poor physical health that curtailed their daily functioning and independence. The witnesses reported their difficulties to be a consequence of their impairments, inadequate treatment, negligent care, physical abuse and associated injuries in childhood.

16.108 More witnesses reported good mental health than good physical health circumstances, as the following table indicates:
Table 97: Current Mental Health Status – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Mental health status</th>
<th>Males</th>
<th>Females</th>
<th>Total witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>8</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Reasonable</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>14</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009

16.109 Seventeen (17) witnesses reported having no particular mental health problems in their adult lives. A number of witnesses acknowledged experiencing both anger and sadness when reflecting on the treatment they were subjected to as hospitalised children, but do not consider that their mental health was adversely affected as a result.

16.110 Eight (8) witnesses reported experiencing a notable level of depression, for which four witnesses reported receiving treatment including medication and hospitalisation. They reported their difficulties to have lessened as they got older and also in response to treatment and counselling.

I was cracking up except I didn’t know it...I remember I was working in...X company...I remember crying and not knowing why, and not being able to stop it and I knew that I was in trouble....The best decision ever was to accept responsibility for my life, that I was the only one who could do anything about it...

I had to go for a lot of therapy then...I was very angry, very aggressive. I was depressed, I didn’t know what was happening to me...I went for a long time, I found it very helpful.

16.111 Six (6) witnesses were categorised as experiencing poor mental health, which was signified by depression, hospitalisation, suicidal thoughts, and alcohol abuse. In some instances witnesses reported these experiences being also associated with violence. One witness reported life-long emotional and mental health difficulties that he believed were the result of the treatment and/or abuse he was subjected to in a psychiatric hospital as an adolescent.

Effects on adult life

16.112 Approximately half the witnesses who reported being abused as children in hospital facilities described life-long negative effects of the abuse they experienced, including being hospitalised and treated for depression and suicidal behaviour, abusing alcohol, and experiencing relationship difficulties, social isolation and continued feelings of anger.

The nightmares were there but gradually they stopped... I lost me childhood, I lost me schooling, and I lost me confidence.

16.113 The following table lists the difficulties described by the 17 male and 14 female witnesses in their adult lives, in order of frequency. They are not mutually exclusive and were not prioritised by witnesses, who could report more than one effect.
### Table 98: Reported Effects on Adult Life – Male and Female Hospitals

<table>
<thead>
<tr>
<th>Effects on adult life*</th>
<th>Number of reports</th>
<th>Effects on adult life*</th>
<th>Number of reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td>10</td>
<td>Abuse not easily forgotten</td>
<td>10</td>
</tr>
<tr>
<td>Counselling required</td>
<td>8</td>
<td>Anxious and fearful</td>
<td>5</td>
</tr>
<tr>
<td>Abuse not easily forgotten</td>
<td>7</td>
<td>Lack of self-worth</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>7</td>
<td>Counselling required</td>
<td>4</td>
</tr>
<tr>
<td>Feeling isolated</td>
<td>6</td>
<td>Angry</td>
<td>3</td>
</tr>
<tr>
<td>Lack of self-worth</td>
<td>6</td>
<td>Tearfulness</td>
<td>3</td>
</tr>
<tr>
<td>Mood instability</td>
<td>6</td>
<td>Feeling different from peers</td>
<td>3</td>
</tr>
<tr>
<td>Aggressive behaviour – physical</td>
<td>5</td>
<td>Feelings related to being a victim</td>
<td>3</td>
</tr>
<tr>
<td>Lack of trust</td>
<td>5</td>
<td>Lack of trust</td>
<td>3</td>
</tr>
<tr>
<td>Post-traumatic effect</td>
<td>5</td>
<td>Post-traumatic effect</td>
<td>3</td>
</tr>
<tr>
<td>Anxious and fearful</td>
<td>4</td>
<td>Unable to show feelings to partner</td>
<td>3</td>
</tr>
<tr>
<td>Feelings related to being a victim</td>
<td>4</td>
<td>Loner</td>
<td>2</td>
</tr>
<tr>
<td>Loner</td>
<td>4</td>
<td>Nightmares</td>
<td>2</td>
</tr>
<tr>
<td>Suicidal feelings or attempt</td>
<td>4</td>
<td>Overprotective of children</td>
<td>2</td>
</tr>
<tr>
<td>Aggressive behaviour – verbal</td>
<td>3</td>
<td>Overly compliant behaviour</td>
<td>2</td>
</tr>
<tr>
<td>Feelings related to being powerless</td>
<td>3</td>
<td>Sexual problems</td>
<td>2</td>
</tr>
<tr>
<td>Nightmares</td>
<td>3</td>
<td>Somatic symptoms</td>
<td>2</td>
</tr>
<tr>
<td>Overprotective of children</td>
<td>3</td>
<td>Suicidal feelings or attempt</td>
<td>2</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>3</td>
<td>Withdrawal</td>
<td>2</td>
</tr>
<tr>
<td>Unable to settle</td>
<td>3</td>
<td>Alcohol abuse</td>
<td>1</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>3</td>
<td>Fear of failure</td>
<td>1</td>
</tr>
<tr>
<td>Aggressive behaviour – psychological</td>
<td>2</td>
<td>Feeling isolated</td>
<td>1</td>
</tr>
<tr>
<td>Gender identity and sexual problems</td>
<td>3</td>
<td>Feelings related to being powerless</td>
<td>1</td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>2</td>
<td>Issues of needing approval</td>
<td>1</td>
</tr>
<tr>
<td>Unable to show feelings to children</td>
<td>2</td>
<td>Mood instability</td>
<td>1</td>
</tr>
<tr>
<td>Unable to show feelings to partner</td>
<td>2</td>
<td>Sleep disturbance</td>
<td>1</td>
</tr>
<tr>
<td>Tearfulness</td>
<td>1</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Fear of failure</td>
<td>1</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Over harsh with children</td>
<td>1</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

Source: Confidential Committee of CICA, 2009
n = 17 male and 14 female
*Witnesses could report more than one effect and male witnesses reported a wider variety of effects

The experience of feeling abandoned by parents and family was frequently reported by witnesses in relation to their hospitalisation. Thirteen (13) witnesses, especially those who remained in hospital for a substantial period of their childhood, remarked on the sense of loss...
they experienced. Several witnesses commented that their admission to hospital was a
distressing experience for their parents, and in some instances led to a sense of alienation from
the family members who had remained at home. Many witnesses commented that, as a result of
being hospitalised, they felt different from their siblings and less a part of their family:

I had my own ways of doing things, I was bold...what they... (family) ... would call bold,
because in the hospital you had to fight, I had to fight for whatever...to be myself,
whatever that was, They ...(family) ... found that difficult.

I remember losing any sense of belonging, or any sense of family at quite an early age.

It was very difficult to fit back into the family when discharged from hospital, I remember
being brought home and remember there was a party and I was taken around to each
one of them ... (siblings) ... and I didn't know any of them...distressed...and that was
hard.

Witnesses commented that childhood experiences of separation and isolation made it more
difficult to form close attachments with their own partners and children. Witnesses who were
sexually abused described a particular difficulty in relation to intimate relationships in adulthood.

I was very angry with my husband and then I said “He doesn't deserve this”... I had to
let him alone...he was a good man ... I had to look at my own issues... we are still
together anyway!

Witnesses who were admitted to hospital from families where there were close and affectionate
relationships described being shocked to find themselves both witnessing and being subject to
abuse they had not previously encountered. A number of these witnesses described being now
fearful of authority and generally more anxious in their adult lives than their siblings who had
remained at home. Two (2) of these witnesses commented on the reactivated trauma they
experienced when their own children were admitted to hospital many years later.

The lack of formal education combined with years of being treated as a sick and disabled
person while in hospital was reported by many witnesses to have had a long-term negative
impact on their lives. Alcohol abuse, depression and suicidal thoughts were reported by
approximately one quarter of the witnesses as life-long consequences of their childhood abuse
experiences. Counselling was reported to have helped some witnesses address issues related
to their past.