
Injurious Histories

2.1 Introduction

Every care leaver has a unique history. Some were treated well, while others suffered dreadfully. Most experienced a mix of the good, hurtful, and indifferent that is humanity's usual lot. However, amidst that variance was systemic abuse and neglect. The Australian Senate describes 'wide scale unsafe, improper and unlawful care of children' (Senate Community Affairs References Committee 2004: xvi). Ireland's Ryan Report found that 'violence and beatings were endemic within the system' (Ryan 2009a: 20). Similarly, Canada's Truth and Reconciliation Commission (TRC) found 'institutionalized child neglect, excessive physical punishment, and physical, sexual, and emotional abuse' (The Truth and Reconciliation Commission of Canada 2012: 25). Those descriptions are characteristic of every major report on care experiences in the last two decades.¹ There are, of course, differences – absconding children froze to death in Canada, not Australia. Still, the overall similarities are strong. Around the world, underfunded and underregulated care systems injured young people thought inferior by virtue of their ethnicity, class, perceived morality, or receipt of charity (Ferguson 2007).

Reflecting on evidence from Australia, Canada, Ireland, and New Zealand, this chapter outlines some of the injuries that survivors experience(d). Not all redress programmes respond to the same injuries; I will later argue that programmes should have pathways distinguished by the type of injuries they redress. To help set up that argument, this chapter introduces distinctions between injurious acts and their consequences;

¹ These reports include the following: (Forde 1999; McAleese 2012; Royal Commission into Institutional Responses to Child Sexual Abuse 2017a; Ryan 2009a; Senate Community Affairs References Committee 2001, 2004; The Royal Commission of Inquiry into Historical Abuse in State and Faith-Based Care 2020a, 2020b; Wilson and Dodson 1997; The Truth and Reconciliation Commission of Canada 2015b, 2015c).

between interactional and structural injuries; and between individual and collective injuries.

2.2 Problems with History

Institutional out-of-home care was a nineteenth-century response to changes wrought by colonisation, urbanisation, industrialisation, and the expanding demands of capitalism. By the beginning of the twentieth century, the relevant states had assumed legal responsibility for all children in out-of-home care; however, they often delegated primary care responsibility to third parties. Although only public authorities could legally take a child into care, in practice, family, religious, and community figures put people into care without regard for the law. The survivor might, therefore, never be legally recognised as a ward of the state. And once placed in a care facility, residents were submerged in systems in which they had little voice and less agency.

Some young people resided in foster homes that mimicked a nuclear family. Other residences were associated with agricultural labour, often on private farms. Survivors might live in cottages or group homes in which one or more care staff supervised a small number of young people. Several cottages could constitute a larger complex. For example, in 1961 the Retta Dixon Home in Australia's Northern Territory had eight six-bedroom cottages, accommodating a maximum of eighty residents (Royal Commission into Institutional Responses to Child Sexual Abuse 2015c: 15). Although group homes, farm stays, and foster care were usually preferred, considerations of cost and public convenience meant that many care leavers resided in large institutions. These included residential, industrial, therapeutic, and farm schools, along with orphanages, borstals, reformatories, and psychiatric hospitals. Those institutions could house hundreds of residents and were often operated by charitable societies or religious orders. Bigger institutions often get more public attention – four of the inquiry reports cited in this chapter attend only to large institutions (Forde 1999; Quirke 2013; Ryan 2009a; The Truth and Reconciliation Commission of Canada 2015e).

Being in care meant occupying a marginal social and legal status, and the quality of the historical record reflects that low standing. Redress programmes need information about the survivors' care experience. Every programme confronts major challenges arising from the poor quality of information now available about people when they were in care. There is an ever-growing wealth of care histories, the most notable

include the reports published by large public inquiries (see footnote 1 in this chapter). These reports are authoritative sources of information, providing impetus for establishing redress programmes and evidence for their operations. However, all care history ultimately depends on two major information sources – historical records and present testimony. Both forms of evidence create such difficulties that even basic facts become contestable.

Written records are a major source of evidence in redress. But their poor quality, absence, and incompleteness serve as impediments (Fawcett 2009). Privacy laws impede access, and relevant records are often dispersed across different institutions and organisations, both public and private. If they still exist, those institutions have often changed their names, constitutions, and locations. It is hard to find records; even their present holders may not know what records they have or what they contain. To illustrate the difficulties, Ireland's Ryan Report states that 170,000 people were legally resident in the industrial schools and potentially eligible for redress from the Residential Institutions Redress Board (RIRB) (Ryan 2009b: 41). But the RIRB worked with a much lower figure: it counted 41,000 care leaver records (Private Communication from Theresa Fitzgibbon of the Residential Institutions Redress Unit, 31 August 2015). Later analysis would suggest that the real figure was lower still – around 37,000 (O'Sullivan 2015: 203). In 2019, the Ryan Commission revised its estimate to 'approximately 42,000 or somewhat higher' (Ryan 2019).

The number of care leavers is a basic fact. Uncertainty regarding that fact makes it difficult for a redress programme to estimate the number of survivors it needs to work with. Further uncertainties compound the problem, as policymakers will not know the prevalence of differing injuries; the survivors' post-care mortality rates; whether or not living survivors will learn of the redress programme; and, should the survivor be injured, alive, and know to apply, if they will actually lodge an application. The unsurprising result is that programmes often wildly misestimate expected application numbers.

For survivors, records access provides information about their early lives and family members. Records access is also necessary to identify and correct errors, and, for Indigenous peoples, control over their data is part of sovereignty (Golding et al. 2021: 1637; Kukutai and Taylor 2016). However, archival practices reflect what was thought useful at the time. That rarely included information about the survivors' daily life in care. The lack of information reflects both the low value placed upon survivors and the semi-private nature of care. When the primary carer was a private individual, records are usually very different in quality and kind

when compared to the more formal records of large institutions. Many records were (and are) private property and were destroyed when agencies culled their archives. Some records disappeared when institutions ceased to function. Destruction could also be accidental as flood, fire, and the accidents of time ravaged neglected archives. Canada's TRC devotes two chapters to the inordinate number of fires in residential schools that often destroyed files held on site (The Truth and Reconciliation Commission of Canada 2015c: chapter 38; 2015d: chapter 18). What remains is often meagre, reflecting historical understandings of care as shameful and best concealed. The private lives of young people in care often went unrecorded – no one took photos of them or documented their experiences (Battley 2019).

Testimony is the second major source of evidence for care histories. Testimony offers information about the direct experience of care and provides historical accounts with authenticity. Providing otherwise unavailable information, the use of testimony in official reports gives survivors voice in the telling of their own stories. Having their words in print enables survivors to see their accounts publicly acknowledged as true. It also provides otherwise bulky bureaucratic reports with human interest as private memories, long thought shameful, are now eagerly sought by inquiries that honour those who produce the most appalling accounts. But testimony also presents the historian with problems, including bias. Sweeping claims about the nature of care are often supported by quotations that might not reflect general experience. The survivors who choose to testify before commissions of inquiry are a self-selected minority, whose experiences may be unrepresentative. For example, a 2014 hearing in Perth for the McClellan Commission heard testimony from eleven survivors, of whom ten had received the maximum payment of AUD\$45,000 from Redress WA.² Yet Redress WA provided maximum payments to only 20 per cent of validated applications, and not all survivors got redress. The survivors who testified experienced the worst forms of abuse and had the resources needed to obtain commensurate settlements – a rare combination.

² The eleventh survivor, 'VV', did not specify their redress quantum; however, their evidence suggests that they also received AUD\$45,000 (Royal Commission into Institutional Responses to Child Sexual Abuse 2014c).

Public inquiries respond to that methodological problem by drawing on testimony provided by survivors in private sessions and submissions. However, again they confront bias. Chapter 10 addresses the accuracy of testimony; here I attend to the structuring role played by its collection. Most inquiries enable individual survivors to relate their experiences of care and its consequences to a commissioner in a private session. These private sessions are relatively short. Most last less than two hours and survivors rarely have more than one session. Not only do time limits impose hard restrictions on what can be said, inquiries cue survivors with template narratives (Niezen 2016: 928). Survivors are told to expect and produce graphic testimony about terrible abuse. For example, New Zealand's Shaw Commission instructed survivors to

Speak about your life before, during and after going into care, as well as the effects of abuse on your family, whānau and communities. (Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions 2020)

The support these inquiries provide – including facial tissues, emotional respite areas, and therapeutic workers – indicate that testimony will (and should) be traumatic. Those expectations shape testimony. Survivors who did not have a traumatic experience may choose not to speak. And when survivors speak, they may accentuate that which they think matches everyone's expectations. My point is not to cast doubt upon their testimony; instead my point is that the collection method(s) affects the available information. The inquiries that inform public understandings of care histories are not exceptions to that broadly recognised rule. And further procedural considerations bear reflection. Commissions of inquiry are limited by available information, as well as their resources, remits, and research methodologies (Scruton 2004). Their work is further shaped by the inquiry's pragmatic needs for information, services, and funding; its need to encourage stakeholder participation, including those who might be comprised by the inquiry; and its need to do (and not do) what will encourage governments to act on its recommendations. All those considerations affect the evidence available to redress policymakers.

2.3 Survivors' Injuries

Historical uncertainty shapes how redress programmes operate. Nevertheless, programmes need to decide what injuries will be eligible for redress and how to apportion monies to different types of injury.

Most programmes distinguish between injurious acts and their post-care consequences. Injurious acts include abusive events, such as physical blows, sexual touching, or medical mistreatment, while consequential damage is harm that results from injuries suffered in care. The act/consequence distinction is commonplace, but a better understanding of redress requires two further distinctions: between the interactional and structural causes of injuries, and between individual and collective forms of injury. Those distinctions are analytic. Neither the act/consequence, the structural/interactional nor the individual/collective distinction sort all of the survivors' complex injurious experiences into unique categories. Instead, these distinctions help reveal the complexity of those experiences and inform later analysis.

Catherine Lu distinguishes between interactional and structural injuries according to their causes (Lu 2017: 33–34). Interactional injuries arise from wrongful interpersonal acts, while structural injuries derive from social practices and institutions. Often taking conventional forms, structural injuries are perpetrated as people implement processes, follow rules, and apply norms. To illustrate the interactional/structural distinction, a responsible adult who refuses to permit a child to get needed medical treatment commits an interactional injury. But that failing could have a structural aspect if it results from budget decisions that, when combined with social norms and staffing difficulties, create an environment where disease is rife and treatment difficult. Canada's TRC argues that poor diet and sanitation, overcrowding, and the lack of appropriate isolation facilities aggravated the tuberculosis that killed thousands of Indigenous children (The Truth and Reconciliation Commission of Canada 2015b: 378f). Those are structurally caused injuries, experienced by individuals.

Many injuries have both structural and interactional aspects. Diane Chard describes a physical assault by two staff members in New South Wales as follows:

[They] beat me while I was in the isolation cell. They bashed me with their hands and feet. They kicked and punched me. They bounced me off every wall. Gordon bashed my ears with his fists. I was bleeding from the ears. I was knocked unconscious and I urinated on myself. (Royal Commission into Institutional Responses to Child Sexual Abuse 2014a: 4960)

It is easy to read this assault as an interactional injury. But its structural aspects are equally important. Chard's assailants were staff members operating within an institutional power dynamic. Structural power

disparities often shape abuse. Not only were there distinctions between staff and residents, there were also informal hierarchies between residents. For example, Queensland's Forde Inquiry was told that 'most of the older boys in Westbrook [Training Centre] had a smaller boy who would act as their "girlfriend" and have to submit sexually' (Forde 1999: 132). Those informal structures could interact with formal aspects of the institution when institutional staff condoned bullying or used bullies to help keep order.

Wherein cause distinguishes interactional and structural injuries, the difference between individual and collective injuries concerns the nature of the injured party. Many survivors experienced their first care-related injury when they were wrongfully removed from their family. That injury has both individual and collective aspects. Not all removals are injurious. Young people entered care for a variety of reasons. Some were orphans. Others had parents who could not, or would not, care for them, and some parents surrendered their children voluntarily. But other children were wrongfully taken into care. Canadian and Australian reports document the genocidal removal of Indigenous children – a clear example of a collective injury (The Truth and Reconciliation Commission of Canada 2015e; Wilson and Dodson 1997). But forced removals were not restricted to Indigenous populations; women housed in Ireland's Magdalene asylums were prohibited from keeping children with them. Prejudice against the needy, the working classes, and minority religions and ethnicities underpinned systemic wrongdoing (Swain and Hillel 2017). If the person, or their family, was poor, disabled, itinerant, homeless, unmarried (either 'fallen' or widowed), Indigenous, unemployed, alcoholic, or criminal, that could justify taking a young person into care. Those removals injured individual young people. They also collectively injured their families, communities and, in the case of Indigenous survivors, their peoples.

Once in care, survivors could experience a range of differing injuries. Redress programmes often distinguish between physical, sexual, and psychological/emotional abuse. These injuries can have both individual and collective aspects, and interactional and structural causes. A single act can co-create different forms of abuse – to experience sexual or physical abuse usually entails an emotional assault. Despite the public attention paid to physical and sexual abuses, Joanna Penglase argues the

worst abuse was psychological (Penglase 2007: 142–43). *Lost Innocents* echoes her judgement, quoting a Victorian survivor saying, ‘the main abuse was psychological’. Survivors were persistently told, “‘You’re no good.” “You will never be any good.” “You will amount to nothing”, that sort of thing’ (Senate Community Affairs References Committee 2001: 83). Survivors were degraded by staff who told them that they were worthless and inferior or offered racist insults. From a structural perspective, frequent abuse contributed to psychologically injurious environments. Young people need environments of security, affection, and love. However, many care leavers were forced to live with their abusers in environments where violence and humiliation were normal.

The most fundamental need for the emotional development of a young child is to be shown love and affection, to be nurtured and wanted. The lack of these essential human qualities was pervasive in institutions and was commented upon or referred to in literally every submission and story. (Senate Community Affairs References Committee 2004: 92)

Survivors were subject to systemic attacks on their personal and cultural identities. A basic depersonalisation technique was renaming. Many institutions assigned numbers to residents (religious institutions might use saints’ names) to sever survivors from their birth families and cultures. Survivors might be falsely told that their parents had died or that they had been abandoned. Siblings were split up and young people were assigned false birthdates and birth locations and given false information about their family (The Royal Commission of Inquiry into Historical Abuse in State and Faith-Based Care 2021: 30, 250). The ethnicity of many Indigenous children was hidden (The Truth and Reconciliation Commission of Canada 2015b: 143; Ministry of Social Development 2018c: 7). Indigenous residents were denied cultural knowledge and skills and those who attempted to speak Indigenous languages might be subject to punishment.

[T]hey used to tell us not to talk that [Indigenous] language, that it’s devil’s language. And they’d wash our mouths with soap. We sorta had to sit down with Bible language all the time. So it sorta wiped out all our language that we knew. (Anonymous, quoted in Wilson and Dodson 1997: unpaginated)

Carers would also hide efforts by birth families to contact care recipients. I met one New Zealander who spent her childhood believing that she had been abandoned, but learnt as an adult that social services had consistently blocked her birth mother’s efforts to contact her (England 2014:

23). Family contact might depend upon good behaviour (Stanley 2016: 74). In other cases, parents and family were denied access (Senate Community Affairs References Committee 2004: 17–18; Ryan 2009a: Volume 1, p. 38). Many survivors were trafficked internationally (Child Migrants Trust 2018). Canada received the largest number of British migrant children, with approximately 100,000 arriving between 1869 and 1932 (Library and Archives Canada 2018). Others went to Australia, New Zealand, and elsewhere. Survivors often moved between different residences. In New Zealand, some experienced ‘as many as 40 or more’ placements (Henwood 2015: 13). Change might be sudden and disruptive. Residential instability was itself injurious as young survivors had existing relationships abruptly severed or were denied opportunities to form long-term caring relationships (Turner et al. 2019).

Disciplinary systems inflicted physical abuse. Physical abuse included slaps, punches and kicks, assaults with weapons, and forcing residents into painful positions, such as kneeling, for long periods. Disciplinary assaults could be inflicted by staff and peers.

[I]nstitutions or religious orders allowed, even encouraged, sadistic and excessive punishment. Systemic beatings designed to break down the will and subjugate ... draw parallels to stratagems used in concentration camps. (Senate Community Affairs References Committee 2001: 80)

Punishment-as-psychological abuse included long periods of isolation. ‘They used to lock us up in a little room like a cell and keep us on bread and water for a week if you played up too much’ (Wilson and Dodson 1997: chapter 10). Every major report includes descriptions of extreme shame-based discipline techniques, including enforced public nudity. For example, a child who urinated in their bed might be beaten while nude, forced to wear nappies, or made to wear the soiled bedding (Senate Community Affairs References Committee 2001: 84). ‘With few exceptions, the arrangements for handling bed-wetting were described as inducing fear and terror on a constant basis’ (Ryan 2009c: 59).

Structural underfunding contributed to malnutrition, poor quality accommodation, and inappropriate clothing. In Ireland’s industrial schools, ‘malnourishment was a serious problem’ (Ryan 2009a: 23). In Australia, ‘[n]umerous accounts were given of children always feeling hungry’ (Senate Community Affairs References Committee 2001: 85). In some cases, the food was plain or unappetising. In others, hunger caused survivors to steal food or provide services to those who would feed them. Poor clothing and housing was normal. Survivors frequently describe

having to wear ragged, ill-fitting clothing that stigmatised them (Senate Community Affairs References Committee 2004: 90). And '[t]he physical infrastructure of missions, government institutions and children's homes was often very poor' (Wilson and Dodson 1997: chapter 10). Dormitories were cold, draughty, and unsanitary. 'Many survivors recalled not having enough blankets at night' (Royal Commission into Institutional Responses to Child Sexual Abuse 2017b: 65). In 1923, the Canadian Indian agent G. S. Pragnell noted:

The gist of the Indians [sic] complaint is that the boys, that is, the smaller boys are far too heavily worked at such work as logging for the school supply of fuel in the winter and that the boys are quite insufficiently dressed as to be exposed to the cold weather in such work. The fact that so many boys died there this Spring of pneumonia has, of course aggravated and lent colour to their complaints. (Quoted in, The Truth and Reconciliation Commission of Canada 2015b: 341)

Poor nutrition, bad clothing, and unhealthy accommodation contributed to high levels of illness and injury. Medical treatment could be rudimentary, with undiagnosed illness and injuries left to heal (Ryan 2009c: 98). Poor dental care led to persistent oral health problems (Senate Community Affairs References Committee 2004: 111). In some cases, residents were subject to medicalised assaults, with staff inflicting unnecessary genital inspections, electroshock therapy, and involuntary sedation (Royal Commission into Institutional Responses to Child Sexual Abuse 2017b: 73; The Royal Commission of Inquiry into Historical Abuse in State and Faith-Based Care 2020b: 73). Some survivors were subject to medical experimentation, including vaccine and hormone trials.

Structural underfunding encouraged the use of residents for labour, either within the institution or by hiring them out. Contemporaries believed that labour enabled young people to learn usable skills, defray the costs of their upkeep, and contribute to the community. Labour was often disguised as practical education (The Truth and Reconciliation Commission of Canada 2015c: 132ff). Male residents would be taught construction, agriculture, and light industry by working as builders, farmers, and fabricators. Females would launder, tailor, do beadwork, or care for younger residents. Young labourers experienced high rates of work-related injuries (Senate Community Affairs References Committee 2001: 88). Many survivors describe their experiences as slavery. In the words of one Australian, "Foster care" meant being "farmed" out as [a]

temporary worker. I was sent to those who needed a slave & a slave I was' (Senate Community Affairs References Committee 2004: 121).

The failure of care systems to identify and investigate injurious practices was an underlying structural injury. To prevent exposure, carers might control residents' contact with outsiders. External inspections might be 'carefully stage-managed' (Senate Community Affairs References Committee 2004: 178) with institutions notified in advance so that they could manage the intrusion (Ryan 2009a). External visits might occasion better food and clothing, accompanied by warnings against 'informing'. When social workers visited the Parramatta Training School for Girls in New South Wales, the 'superintendent told girls to keep their mouths shut and say that everything was fine' or risk the consequences (Royal Commission into Institutional Responses to Child Sexual Abuse 2014b: 5). Institutions developed customs and habits that normalised abuse (Parkinson and Cashmore 2017: 89). While each jurisdiction received numerous reports describing the abuse and neglect of survivors, these rarely resulted in effective responses. For example, a 1956 investigation into charges of sexual abuse against the principal of Saskatchewan's Gordon's School was neither independent nor impartial; it was carried out by a subordinate teacher, who exonerated his superior (The Truth and Reconciliation Commission of Canada 2015a: 104). Medical staff might be similarly inclined. In Ireland, '[t]he area of neglect in healthcare most frequently reported by witnesses was the absence of investigation into the cause of non-accidental injury' (Ryan 2009c: 98). A lack of effective systems for identifying and investigating abusive behaviour permitted abusers to operate with impunity (Ministry of Social Development 2018c: 7).

The consequences of care are as variable as the individuals who experienced it. Many care leavers live full and successful lives. For others, damage resulting from their care experiences includes illness and unemployment along with broken family and community relationships (Golding and Rupan 2011: 8–9, 25). Not only does consequential damage offer potential grounds for a redress claim, it affects how survivors interact with redress programmes and, as a result, how those programmes operate (Lundy and Mahoney 2018: 273). This final section surveys some of the more common injurious consequences experienced by care leavers as both individuals and groups.

Difficulties with personal relationships are among the most widespread injurious consequences of abuse in care. Denied secure loving relationships as children, many care leavers did not develop the ability to build mature relationships as adults (Cloitre, Cohen, and Koenen 2006: 6–8; Reimer et al. 2010: 1–2; Stanley 2016: 155). A recent study found that up to 90 per cent of maltreated children have ‘insecure attachment patterns’ (Van der Kolk 2017: 376). Problems with anger management, mistrust, and social skills hamper relationships with spouses and children. Many survivors are socially isolated, which can be psychologically injurious and a risk factor for other negative outcomes. Survivors who were depersonalised or trafficked lost contact with some or all members of their family. Some survivors became abusers, including abusers of other survivors, meaning that redress programmes cannot sharply distinguish survivors from offenders (The Truth and Reconciliation Commission of Canada 2015c: 414). Abuse can have criminogenic consequences. Criminal employment does not depend upon educational qualifications and strong prosocial skills, which is one reason gang membership is an attractive survival option for survivors who were ill-prepared for life after care (Henwood 2015: 25). Both within institutional care and then once released, criminal gangs provided survivors with identities and social groups (Stanley 2016: 140–43; The Royal Commission of Inquiry into Historical Abuse in State and Faith-Based Care 2020b: 92). For many, lifetimes of alienation and rejection contribute to feelings of distrust towards any authority.

The injurious consequences of miseducation include high rates of illiteracy and innumeracy that operate alongside psychological difficulties to impair the survivors’ remunerative prospects (Fernandez 2016: 232). As the Australian survivor Roger Matthew (a pseudonym) relates,

I left there barely literate; I could read but not really comprehend the meaning. So I could not express myself in writing and anything that looked official filled me with such anxiety that I would avoid dealing with it. I feel enormously resentful today – they stole my future along with my childhood. What kind of work could I do after that educational deprivation? (Royal Commission into Institutional Responses to Child Sexual Abuse 2017b: 146)

Many survivors experience difficulties in holding down jobs or maintaining long-term employment. A survey of Queensland survivors found that 18 per cent ‘regarded themselves as poor or very poor’, which was six times the rate for other Queenslanders (Watson 2011: 3). Another 46 per

cent said they were 'just getting along', the comparative number in the general population was 26 per cent.

Compounding social and economic marginalisation, abusive care experiences are associated with collectively higher morbidity (Anda et al. 2006; Brennan 2008; Chartier, Walker, and Naimark 2010; Evaluation, Performance Measurement, and Review Branch: Audit and Evaluation Sector 2009; Felitti 2002; Ferguson 2007; Fuller-Thomson and Brennenstuhl 2009; Higgins 2010; Llewellyn 2002; McEwen and Gregerson 2019). Poor medical and dental care can cause or aggravate physical health problems later in life. Survivors are more likely to have long-term difficulties with addiction and substance abuse and more likely, than non-care leavers, to attempt suicide (The Royal Commission of Inquiry into Historical Abuse in State and Faith-Based Care 2020b: 24). More generally, the socio-economic disadvantages experienced by many survivors contribute to mental and physical illness while simultaneously inhibiting effective treatment.

From a structural perspective, survivors' experiences of harmful consequences intersect with existing social injustices. For example, a lack of mental health services combines with discriminatory social norms regarding mental illness to compound the difficulties survivors have with psychological disorders. And care leavers often experience clusters of disadvantages, as health and personal issues combine with educational deficiencies and poverty to reinforce marginalisation (Watson 2011). Damage can be intergenerational if survivors did not learn how to be good parents. Often the children of survivors follow similar paths and families can comprise three or four generations of survivors (Evaluation, Performance Measurement, and Review Branch: Audit and Evaluation Sector, 2009: 45; Ministry of Social Development 2018c: 8). Some studies suggest that high stress experiences in systemically injurious care environments can alter the expression of genes that govern hormonal stress responses in ways that affect parenting behaviour (Van Wert et al. 2019). The research on epigenetics is contested (Carey 2018), but it is clear that the negative effects of care 'can be lifelong and profound' (Independent Inquiry into Child Sexual Abuse 2018: 73). Survivors experience pervasively injurious effects that provide grounds for compensation, while at the same time making it hard for many to engage with redress programmes.

The major inquiry reports in the exemplar jurisdictions all tell remarkably similar care histories. Despite chronic historical uncertainty, they underline general patterns of structurally injurious care practices. These practices were a consequence of poor regulation and underfunding which, in turn, meant that survivors experience(d) systemic injurious acts and consequences with interactional and structural causes, and individual and collective effects. Although survivors are individually diverse, as populations they are severely marginalised. These disadvantages, as later chapters emphasise, shape how monetary redress programmes operate. They also provide a foundation for a common set of normative standards applicable to any redress programme. Those standards are the next chapter's subject.