

Witness Name: CATHERINE MARGARET HICKEY

Statement No.: WITN0391

Exhibits: WITN0391002 – WITN0391005

Dated: 2 August 2021

ROYAL COMMISSION OF INQUIRY INTO ABUSE IN CARE

FIRST WITNESS STATEMENT OF CATHERINE MARGARET HICKEY

I, CATHERINE MARGARET HICKEY, will say as follows: -

1. My full name is Catherine Margaret Hickey. I live at [GRO-B] I work as a freelance tour guide for Grand Circle Tours.
2. I am representing my brother, Paul John Gerard Norbitt Hickey, who died in state care at Porirua Hospital in 1980 at 20 years of age.
3. I was born in Palmerston North on [GRO-B], the third child in a family of four. My parents were Mary and Richard Hickey. I have two older sisters, [GRO-B] [GRO-B] and [GRO-B].
4. Paul was born in 1960 in [GRO-B] the baby of our family, and it is his time in state care and ultimately his death in state care which is at the centre of the story of our family. The purpose of this evidence is to tell that story.
5. Our family is Irish Catholic, and we later learned we have connections to Tainui from our paternal grandmother. Paul's religious and cultural background did not seem to matter and was not taken into account at Porirua Hospital. The hospital knew he was Catholic but at the time our connections to Tainui were not known.
6. My mum passed away in 2011 and my father passed away in 2005. At the time of mum's death I promised I would make sure to shine a light on Paul's story.

7. Paul's experiences took an unspeakable toll on our family, and on my mum in particular who remained heartbroken for the rest of her life. Paul was stolen from us and there is no other way to describe it. Our family dissolved because of what happened to Paul, and all of us have felt the impact continuing over the ensuing 40 years since his death.

Paul's child hood

8. Paul was the baby of our family and the only boy. I was only 18 months older than him and we were always very close.
9. At age 6, Paul was riding a bike for the first time at a friend's house. He was without a helmet, as was the norm at the time. He was struck by a truck and suffered a serious head injury. Paul's skull was crushed and the parietal and frontal bones were shattered. This meant he was left with no protective barrier between his skull and the left side of his brain.
10. Paul was in a coma for nine weeks. He received his last rites as his chances of survival were marginal at the time. Despite all odds, Paul eventually awoke and was cognitively alert, although he began the long process of rehabilitation and learning to walk again. His entire left side was paralysed.
11. Within months, Paul was back in his mainstream school.
12. Paul's right arm remained strong and so he was capable of many things. He could build a 25 storey card house with one arm.
13. Paul was a bright child. He had no cognitive impairments at all. He loved music and wood work. He wanted to be an architect. He had a big telescope and he taught my sisters and I about astronomy.
14. However; there were no agencies or organisations or any state assistance set up to support people like Paul and their families. The fabric around our home life began to disintegrate. We lived on a farm at the time, and my dad had a well paying job. He was embarrassed by Paul's limp and paralysed arm, because Paul could never play rugby and that did not fit with the macho male kiwi stereotype my father believed in.
15. My father resorted to staying out late with his mates drinking. He was gone for nights at first which then became weeks of absence. He distanced himself from the rest of

the family, and there was never any money for the basic necessities. Eventually he chose to leave the family home, which had a particularly devastating impact on Paul as he was left with no male role model or father figure.

16. My parents divorced and the Catholic Church disowned us as a result. That meant that mum's supports disappeared too. We had moved to a hospital house rental in Gisborne, as dad was a CEO of a hospital. Dad stopped paying rent and we were evicted. Our family moved to Hawkes Bay. GRO-B hated dad for abandoning us, and we remained estranged until he died. My mother did eventually remarry a very supportive man who too tried very hard for a better outcome for Paul without success.

Paul's time at GRO-C

17. Paul received mainstream schooling for a time, at first in Awapuni School in Gisborne, but was bullied terribly. He would often come home from school covered in blood after rocks were hurled at him. When we moved to Hawkes Bay, mainstream schooling became even more difficult. A major contributing factor to this was the level of bullying Paul faced on a daily basis, which only got worse as he was older. He was not safe in mainstream schooling as it was set up at the time.
18. Eventually he was placed at GRO-C where he was amongst adults despite being only 13 years old. His formal education ended at this time and really the only organised activities or training he had after that were things like building letterboxes and doing woodwork. After age 13, he never sat any exams or assessments and never had any chance of getting a qualification of any sort.
19. Paul was articulate and bright, and despite his disability he wanted to learn and normalise his life. Being in GRO-C was not where he wanted to be. He loved music, movies, writing, playing cards and having fun. None of this could come to fruition in the environment he was placed in.
20. Although Paul had a physical disability and a severe head injury, he was cognitively totally aware. He could walk, albeit with a limp, and had normal speech. He was now amongst adults with mental and cognitive disabilities who he could not relate to. Those adults would taunt him, and knew no better. At the GRO-C there was no one who was Paul's age. There were no friends for Paul, and no one to play soccer or tennis with.

21. There seemed to be no one working towards a better outcome for Paul. Mum needed to work full time to support the family. This placed an immense strain on the rest of us children. My sister [GRO-B] and I looked after Paul by getting him ready for school. By the age of 12 I had taken on a parenting role for Paul. I am still consumed by guilt today that I could not do more for Paul and that I did not protect him. I feel guilt that I did not realise the extent of his suffering until too late. The immense sadness, anxiety and disbelief has impacted my whole life.
22. Paul suffered a downward spiral of depression. He was subject to constant bullying from people much older and larger than him. Some of the attendees at [GRO-C] were violent and prone to lashing out and this proved really challenging for Paul. Eventually, after 18 months there, he finally snapped and threatened one of the [GRO-C] attendees with a weapon, demanding that they leave him alone. The [GRO-C] had been well aware of the problems Paul was facing in the facility before that point.
23. The Police were involved. Paul was never prosecuted or detained by Police, He did not have a lawyer or any kind of advocate representing him. A psychiatric assessment was undertaken by the family GP Dr [GRO-C].
24. Dr [GRO-C] advised mum that the best decision would be to institutionalise Paul. He was in a loving and nurturing environment at home but there were no schooling facilities or support agencies equipped to help. Dr [GRO-C] committed Paul, and in doing so took away any of the rights of my whanau to decide Paul's future or wellbeing. In order to commit a child or young person without whanau consent, that child was placed in the care of the state. That is why Paul became a ward of the state at age 15.
25. Mum was very resistant to Paul being institutionalised and would not consent, but the GP assured mum that Paul would be in very good hands and all care would be taken. He assured mum that Paul would be safe there. That could not have been further from the truth.
26. I do not believe Paul should ever have been institutionalised. He may have acted irrationally at times, and he may have suffered from depression. However; there is no doubt in my mind he would have had a positive and empowering outcome if he had a support network around him and was placed in a more holistic, stimulating environment with like-minded people (i.e those who also faced a physical disability) in the same age

bracket, and with care workers who understood his emotional and physical needs. He needed to feel safe and valued.

Paul's time at Porirua Hospital

27. Paul was made a ward of the state in 1975 at age 15, and sent to Porirua Hospital.
28. The day that Paul left is still vivid in my mind. We were living in the Hawkes Bay at the time.
29. Paul later told me that the moment he arrived at the hospital he was stripped. He was stripped both physically and mentally. All his freedoms were taken from him. He could only wear what they told him to wear, and only do what they told him to do. He had long seventies style hair which he loved, and it was all shaved off. He may as well have been living in a German prison camp.
30. Exhibit WITN0391001 attached, is a photograph of Paul just prior to his committal. Exhibit WITN0391002 is a photograph of him at age 17, 2 years after his committal and 3 years before his death.
31. So began years of unimaginable torture for Paul. Some of his experience he told me directly over the phone or by letter, but much of it I learned through speaking to my mother.
32. Paul was treated like an animal. There was no value placed on his young life. He was not seen as a different or isolated case, and was treated just like every other patient there with no consideration of his individual needs. He suffered prolonged and premeditated abuse at the hands of the very people who were entrusted to protect him. He was beaten, raped, forcibly given Paraldehyde injections, and subjected to ECT.
33. ECT was administered if a patient expressed signs of depression, defiance or a "bad attitude" generally, if they protested about their treatment, or simply as standard rehabilitative process (or what was seen as standard at the time). ECT was not just for treatment but also a punishment for certain behaviour. It was impossible for us to question what was seen as justifiable and necessary, and my mother had no rights in regards to determining Paul's treatment. There was no communication to us before Paul had ECT or paraldehyde injections.
34. Mum's access to Paul was restricted. The hospital never gave reasons for this and were very non-committal when she asked for further access. My sisters and I could not

see him at all. Paul would write letters to us but a lot of them were confiscated. He was allowed to call but I believe the calls were monitored. He would ask for help each time we spoke to him, and beg us to get him out of there. The letters Paul wrote were very hard to deal with on every level. I have kept only one of them, which is attached as Exhibit WITN0391003.

35. Mum had a car and a licence so she would drive to visit him whenever the hospital permitted it. Several times she found Paul in a shocking state. He became like a zombie. He had always been thin but this was completely different. By the end of his life he was emaciated.
36. Paul told mum he was being physically and sexually abused. On one occasion he pointed out to mum the staff member who had perpetrated the abuse. Unfortunately I do not know this person's name. Mum went to the matron and to the superintendent (at this time the superintendent was Dr John Hall) and they said they would look into it. Nothing was ever done. Mum would press on, but doors were closed on her and at every turn she rang into a big brick wall. Sometimes she would go to the hospital outside of the allowed times and demand to see Paul.
37. Mum saw Paul with black eyes, and evidence that he was regularly beaten up. He had unrelenting physical injuries. The excuse given was that he had fallen out of bed. He told her that the staff would round up the patients and hose them down with cold hoses. His radio was stolen and he could no longer listen to his beloved music. His watch was stolen to, along with any money he had.
38. Mum told me there were times she arrived and there were excuses as to why she could not see Paul. She was denied the right to see him. She insisted and found him cowering in a corner in the ward, with fresh bruises, black eyes, swollen lips and cuts on his body. She brought this to the hospital's attention and nothing happened. This happened more than once.
39. Mum had practised as a nurse and knew all too well the dangers of the medication they were administering to Paul. He was given paraldehyde and it brought on seizures. His brain was exposed and you could see the movement on the side of his head. He was given shock treatment and had electrodes connected to him. Medication was administered to him anally, to make it work faster.

40. Paul could shower and use the bathroom without assistance and was mostly independent for day to day life. He made a huge effort to be that way, and could tie his shoe laces one-handed. I am not sure what the showering and bathroom facilities were like and whether Paul had any privacy but I do know he did not need help to do those things himself. I do also know the bathroom was one place he was very vulnerable as he told us he was assaulted there several times and despite his independence he could not defend himself with the use of only one arm.
41. Mum begged the Dr [GRO-C] to review Paul's case and release him. Her pleas fell on deaf ears. We as a family were denied any hope of having Paul back in our care.
42. Paul was in the hospital for approx 4 years before he died. I only saw him once in person during that time, when he was granted leave for the weekend to attend [GRO-B]'s wedding. I was allowed to speak to him on the phone 2 or 3 times a year.
43. All of this was happening in the formative years of my own life. Paul had been my baby brother, so close to me in age, and I had then taken on a quasi-parenting role. The loss was huge. I went off the rails a bit, and would bum out of school. I felt guilty that I could not protect Paul and felt I could have done more for him. We felt strongly that he should have been at home with us, where he was loved, and would be safe. [GRO-B] [GRO-B]
[GRO-B]
44. I spoke to mum at length about Paul's situation, when I was around 19 years old knowing that his situation was consuming hers and our every day lives.
45. The only positive experiences Paul described from his time at Porirua Hospital were the student volunteers that would come in on occasion and play cards with him in the day room and a visit to the zoo. He found it refreshing to be treated as an actual person.
46. To the best of my knowledge all meals were provided on a schedule (which was disrupted when Paul was having ECT), and there was an area for games and a television in a day room. By all accounts from Paul, the staff were fairly disengaged and disinterested in his well being full stop and his days were pre-determined.
47. Paul was in Ward 10 initially, then moved into other wards, in 1977 the F ward (used to house women) was judged unfit for continued inpatient use. Those running the hospital at the time would have been aware that there were brutal and barbaric

practices occurring elsewhere in the hospital on a daily basis and have openly admitted this.

Paul's death in state care

48. Paul was found on a bench seat, on Colonial Hill within the hospital grounds, on the **GRO-B** 1980. He died alone, far from his whanau who loved him dearly. He had taken his life **GRO-C**. He had been dead for 3 days when he was found. I have no idea whether he intended he would be found before he died, but it would have taken an incredible amount of determination to inflict such injuries. It is hard to imagine the level of despair he must have felt to do that. Paul took a drastic last resort to escape his tormented existence.
49. I have no doubt that Paul would have been saved if he had been promptly found. His death would not have been quick at all.
50. The grounds were quite large but I do not know why it took so long to find him. I do not know if the staff did not notice he was missing for the first few days. We were not told he was missing, we were only told when they found him.
51. Dr Hall, the Medical Superintendent, contacted my mother about Paul's death.
52. Mum was unable to go to identify Paul's body. Dad had to do it. The police were called as it was a technical suicide and there was a post mortem. Our family were never given the results although I believe mum said she did not want them. There would have been evidence of his profound injuries from his treatment at the hospital. I do not believe any investigation was ever made of the care he received and the circumstances leading up to his death. If there was, our family was never advised. I am not aware of the coroner's process.
53. Paul's death certificate is attached as Exhibit WITN0391004.
54. I have applied for Paul's medical files from Mental Health Records and Capital and Coast Health. **GRO-B** was not in agreement at obtaining these, as she felt the records would not be a true account of his care, it would not contain the correct and accurate information and would be too raw still to deal with.

Impact of Paul's death

55. Paul's accident had already had a significant impact on my parents' marriage. His time at GRO-C and then his admission to Porirua Hospital affected us all, and our whole family unit fell apart. Paul's death had lasting impacts on all of us, and our own relationships.
56. I was pregnant with my first child at the time of Paul's death. I have since had three other children. They are all adults now. I made sure they were fully aware of Uncle Paul's story.
57. It became extremely difficult for me to trust anyone. I was very over protective of my own children and guarded in my relationships. I divorced and remarried. The pain of Paul's loss has never gone away. I am frequently jolted back by every day things. If someone discusses suicide I have to leave the room.
58. There is never a day that I do not think of Paul. GRO-B Mum shed a tear for Paul every day until she died. She was broken by what happened. We always felt we could have and should have done more for him, but the institutions around Paul made that impossible. His abusers were protected by the State, despite our complaints, and his torture continued.
59. I just want to hold Paul close and say "it will be alright Paul, we will take you home now". There is never a day our family does not grieve for Paul. We live with the guilt, the anger, the disbelief and the immense sadness of what has happened.

Redress

60. An apology will not cut it for our family. We are angry and we are sad. We are hurting. What happened to Paul was unnecessary and should never have happened. It was cruel, premeditated and unlawful.
61. Accountability is the most critical part of redress. I read a report from June 2007 (Te Aiotanga – released as a result of the Confidential Forum for former In-Patients of Psychiatric Hospitals in Aotearoa) and it highlights almost word for word what happened to Paul, and how widespread it is. Fourteen years later and nothing has changed.
62. In 2002 I contacted Sonya Cooper at Cooper Legal on the request of my mother, prior to the Forum being announced by the government, but was told that due to Paul being deceased we had no case. That was terribly upsetting for my mother.

63. When Paul would complain or mum would complain about his treatment, they were taunted. Paul was told, who would believe you, you're really the one in the psych hospital not me, it's your word against mine. Those staff felt protected and thought they could act with impunity. Their words made it clear they were well and truly aware of what they were doing, and that it could not simply be explained as part of the accepted treatment tools of the time. There seem to have been little consequences to date and that needs to change.
64. First and foremost, when I think of accountability I believe some of these staff should be subject to criminal prosecution. In my mind, they are rapists, murderers and torturers with victims who were almost completely defenceless.
65. Dr John Hall was the Medical Superintendent throughout Paul's time in Porirua Hospital. He was directly responsible for and full aware of what was taking place. My mother's letters were sent to him directly. Regretfully, I do not have copies of her letters. Dr Hall never replied or made any effort to communicate until Paul's death, when he rang my mother. On the odd occasion in was in the ward when my mother was there and she confronted him directly, but nothing changed as a result.
66. There is of course no sum of money that could replace Paul, and no sum of money that can undo the life-changing impacts on our wider family. However; monetary compensation is at least a signal that the state recognises and accepts its role in what has happened. It feels as if Paul has simply been abused and set aside and we are expected to forget him and keep quiet.
67. We do not want to benefit financially from what happened to Paul but it is only fair and right that there is compensation. It is a small way of the State saying we agree this should never have happened.
68. I would like to start up a trust one day for others in the same predicament as Paul. I saw on the news very recently a beautiful, intelligent, vibrant disabled girl of about 22 years. Her facility had closed, and she was having to go into an aged care facility. It made me wonder what the impact would be on her mental health. I can foresee she would only go into a downward spiral being placed in such a facility.

69.

GROC

GRO-C

70. There are people who need to be held accountable for what they did to Paul. I know that some of them are still alive and I believe some continue to treat patients.
71. A very close friend of mine went to a gathering a few years ago. She a woman there who worked as a psychiatric nurse at Porirua Hospital. The Royal Commission came up in conversation and the woman admitted she knew what had been going on with mistreatment and abuse of patients. My friend mentioned she knew of Paul's situation, and the woman left the gathering.
72. I have written to the Minister of Health, and to the Health and Disability Commissioner. The Minister responded but I felt it went nowhere. Our family consulted Sonya Cooper Law some years ago, but at the time there were no legal avenues for historical claims from the families of those who had died in state care.
73. Our family has come to hang our whole hopes on the Royal Commission of Inquiry into Abuse in State Care. My mother died waiting for Paul's story to be told and his torturers held accountable.
74. I have found the process to get to the point of submitting this statement to be arduous, challenging and immensely draining. I have had to really fight to get to this point, and I am now extremely reliant on the inquiry getting some traction. Every turn of this process has taken time, and has been difficult to navigate. It took 3 years to get a meeting with the commissioner. I felt the commissioner offered strong commitments but then I heard nothing. It was like a dead weight – I had exhausted so much emotion in coming forward and then I received nothing in return. It was another kick in the guts. The process as it exists relies on tenacity and there are many intellectually or physically disabled survivors and their whanau that are not able to continue through to the end. I have had to invest so much into getting to this point and I worry that nothing will come of it.
75. My hope is that the Royal Commission work leads a process that assists civil claims like those of my family, as we have been turned away from every door even though

we have now been knocking at those doors for over 4 decades. I worry about the people that will bow out as the existing pathways are not easy. There are also those involved in Paul's treatment that should face criminal prosecution for rape and assault.

76. The way Paul and others like him were treated is a national shame. I feel that New Zealand seems like a paradise but underneath it is cracked and scarred. It is important that the public knows about this and it is important that people are held accountable.
77. I know that many systems and treatment models will have changed since the time Paul was in care, but it is important that something like this can never happen again to another family like ours.
78. My voice is now for Paul, whose own voice lives within me and my family, and my voice is also for the many others who suffered in a similar way.
79. It is hard to articulate the devastation and absolute feeling of loss of power in every sense of the word. Paul had everything stripped from him and when I think of what it must have been like for him I almost go into a panic state. I feel powerless too. Every piece of my heart feels as if it has been ripped out. It is hard to verbalise how difficult this is. It takes all my resolve and my might to work through it.
80. I have only ever told two people outside my family about Paul's experience in state care. It is still too raw for me to share even with lifelong friends and those that matter most in my life. Recently, when I finally told a close friend she was stunned and told me it makes her ashamed to be a New Zealander. I need more people to hear what happened to Paul, and all those other patients like him. There are so many of us with this burden of pain and grief.
81. Paul's story is like an invisible weight which I always carry. I can never forget it, I can never put it down. It is exhausting to have to keep carrying. There are so many people carrying this weight for so long and it feels as if nothing has been done.
82. Paul endured so much so unnecessarily. Paul was so loved at home, he was in the most loving place he could be and yet the state still chose to take him from us. He was young, vulnerable, paralysed and missing part of his skull. He was alone and separated from his family.

83. This whakataukī makes me reflect on Paul and his life “Kua hinga te Tōtora o Te Waonui a Tāne” – a Totara has fallen in the great forest of Tāne. I have no doubt if Paul had lived he would be a Totara among men, with so much to offer the world.

Statement of Truth

This statement is true to the best of my knowledge and belief (information having been passed onto me by my late mother) and it was made by me knowing that it may be used as evidence by the Royal Commission of Inquiry into Abuse in Care.

Signed GRO-C

Dated 28/07/21