STATES OF JERSEY

INDEPENDENT JERSEY CARE INQUIRY REPORT

Presented to the States on 3rd July 2017
by the Independent Jersey Care Inquiry

STATES GREFFE

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The Report of the Independent Jersey Care Inquiry 2017

Chaired by Frances Oldham QC

Volume 1: Executive Summary

Presented to the States of Jersey

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Executive Summary

Introduction

1.1 Our remit has been to establish what went wrong in Jersey's child care system over many decades. That there were failings is not in dispute. Those failings impacted on children already at a disadvantage, whether through family circumstances, a crime committed against the child or even a crime committed by the child. For many children who were removed from home situations deemed harmful or unsatisfactory, the States of Jersey proved to be an ineffectual and neglectful substitute parent.

1.2 On 6 December 2010, Jersey's Chief Minister made a formal apology to all those who had suffered abuse in the States' residential care system, acknowledging that the system had failed some children in a serious way. On 6 March 2013, the States Assembly formulated the Terms of Reference for what was to become the Independent Jersey Care Inquiry. On that occasion, the Chief Minister, Senator Ian Gorst, said this:

> *"It is the right thing to do for victims of abuse who want to recount their experiences to an independent inquiry. It is the right thing to do for our community so we can be assured that we have done everything possible to establish what went wrong and then to ensure it does not happen again."*

1.3 The 15 Terms of Reference set by the States of Jersey cover many areas. As some of those areas overlap, not every Term of Reference has been dealt with separately in the Report. Every element of the Terms of Reference has been addressed in the Report. After explanation of the Inquiry's processes, the Terms of Reference are addressed in Chapters 2–11 of the Report. Chapter 12 summarises failings and lessons to be learned, and explains how the recommendations have been compiled. Chapter 13 sets out our recommendations. Supplementary material that also addresses the Terms of Reference is provided in nine appendices. These include: a chronology of events significant to the Inquiry's Terms of Reference (Appendix 1); a summary of the accounts of over 200 people whose care histories were heard by the Inquiry (Appendix 2); recommendations on the future of care in Jersey,

received from over 200 sources (Appendix 3);studies of the history of child care and of child care law (Appendices 6 and 7); and key child care policy documents and guidelines on which the Inquiry has drawn (Appendices 8 and 9).

1.4 The Inquiry sat for 149 days of hearings and consultations, allowing over 200 witnesses to give evidence directly. Additionally, the Inquiry considered the evidence of over 450 former residents of, and those otherwise connected to, Jersey's care system. The Inquiry processed and considered around 136,000 documents (a significant proportion of which amounted to many pages). We also undertook over 100 consultations and meetings with agencies and members of the public in Jersey and with child care experts. We record our appreciation of all who have assisted us, particularly witnesses who were formerly in the care of the States of Jersey, many of whom gave evidence of experiences that must have been extremely difficult to recount. Without their courage, this Inquiry would not have been able to perform its work.

1.5 We have conducted our work independently of the States of Jersey, of the Police, of the Judiciary, and of any other organisation or individual in Jersey or beyond. We are impartial and favour no group or individual. We have reached our conclusions on the basis of all the evidence that we have considered.

1.6 Arrangements for protecting the privacy of witnesses are described in the Report. Ciphers have been used for witnesses whose evidence was heard anonymously. This included former residents of care homes who wished not to have their identity in the public domain, and victims of abuse. Persons against whom allegations had been made and who met the criteria set out in the Inquiry's Protocols also were given a cipher ("WN" followed by a cipher number).

History and social context

2.1 Our Report sets out a history of residential child care in Jersey since 1945, including the policies and practices of different periods and how they were shaped by Jersey's particular circumstances. The events leading to the launch of Operation Rectangle, the major inquiry into child abuse, which ran

from 2007 to 2010, are described. Chapter 2 of the Report addresses Term of Reference 4 and describes the social, historical and political background of Jersey and its effect on the oversight of residential and fostering services, the reporting of abuse, the response to such reports and on the Police and other investigations.

2.2 In fulfilling this Term of Reference and considering other aspects of our remit, including lessons to be learned for the future, we explore what is termed the "Jersey Way". At its best, the "Jersey Way" is said to refer to the maintenance of proud and ancient traditions and the preservation of the island's way of life. At its worst, the "Jersey Way" is said to involve the protection of powerful interests and resistance to change, even when change is patently needed.

2.3 The view of Graham Power, former Chief Officer, States of Jersey Police (SOJP), was that a disproportionate amount of power in Jersey was concentrated in the hands of a few people who resisted change on principle. Former Deputy Trevor Pitman described the "Jersey Way" as *"the powerful, the establishment protecting the guilty and ensuring that those who probably should be held to account will not be held to account"*. Deputy Bob Hill said there was a *"culture of fear"* in Jersey, with people afraid to come forward with information or criticisms of others who could have an influence over the informant's job or family. He believed that this culture impacted on child abuse investigations.

2.4 The Howard League has described how, in Jersey, *"Powerful interlocking networks may exclude and disempower those outside of the groups and make it hard for those outside of those networks who have genuine concerns to raise them or make complaints in an effective way. This is likely to be particularly true of deprived, disadvantaged and powerless children".*

2.5 We consider that an inappropriate regard for the "Jersey Way" has inhibited the prompt development of policy and legislation concerning children. Treating children in the care system as low priorities fails those children and shames the society concerned. Equally, a care system in which insufficient effort is made to prevent children from being abused, whether physically, emotionally

or sexually, or a justice system in which insufficient steps are taken to investigate and punish such abuse where it occurs, is indefensible.

2.6 We have had regard to the social divisions in Jersey and their impact on child welfare. We have considered Jersey's distinctive structures and approaches to social policy. The absence of a welfare safety net until recent times, for example, meant that access to relief depended upon the personal judgement of the local Connétable. The Connétable played an important role in the child care system, including the approval of foster parents, applying for admission of a child into care, and reporting to the Attorney General if any child appeared to be in need of care, protection and control. We saw no evidence of any training or expertise being required for this role.

2.7 We have also noted how the shortage and cost of housing have had a marked impact on family life and wellbeing for some families, and on fostering in Jersey, with some potential candidates having insufficient space to accommodate foster children. Pressures on accommodation in Jersey have also had a detrimental effect on the ability of the relevant departments to recruit and retain suitably qualified and trained child care staff from outside the island. We have found strong ties between accommodation and child care practice. Individuals and their families were often provided with accommodation onsite (e.g. at Haut de la Garenne (HDLG)) and their presence influenced the culture of the establishment. Other child care staff had access to accommodation dependent on their employment. At times, this had an inhibiting effect on their willingness to raise concerns about systems, practices or colleagues. We concluded that at no time did the Housing Department accept or discharge the role that it had to play in the States of Jersey's responsibility as the 'corporate parent' of children in care.

Residential and foster care in Jersey and why children were admitted and discharged

3.1 In Chapter 3, we address Term of Reference 1: the type and nature of children's homes and fostering services in Jersey, with a particular focus on the period after 1960. We consider, in general terms, why children were placed and kept in care, and make findings accordingly. We describe both the

institutions established and run by the States of Jersey and those provided by voluntary or charitable organisations.

Residential establishments

3.2 Starting with Jersey Home for Boys (JHFB) and Jersey Home for Girls (JHFG), we describe the homes' operation through to their amalgamation in 1959, when the combined institution became known as Haut de la Garenne. Following the incorporation of Westaway Crèche, HDLG was providing care for up to 67 boys and girls who ranged from weeks old to school-leaving age. We discuss the routes and reasons for children coming into state care, including the significant proportion of children who were admitted at the request of a local Connétable, without any statutory order. In 1986, HDLG finally closed, its occupancy having dropped and children having transferred to La Preference and to Heathfield.

3.3 La Preference was originally run by the Vegetarian Society from 1951 to 1984. All children admitted in this period had to adopt a vegetarian diet and lifestyle, regardless of their preferences, and the Inquiry heard evidence of children being punished for eating meat products. There was only ever one external inspection of La Preference, in 1981. It was taken over by the States in 1984 and was used as a residential home until 2012.

3.4 In December 1986, Heathfield opened to provide residential care for the remaining children left in HDLG. There were a number of significant changes to the organisation and function of Heathfield following its foundation.

3.5 Sacré Coeur was a Roman Catholic orphanage that ran for nearly 70 years before there was any form of inspection by the state. We consider unsatisfactory the casual arrangements that allowed some children to spend their entire childhood in that institution, with no apparent statutory basis and with no social work oversight or input.

3.6 In the late 1960s, the States of Jersey experimented with a small number of Family Group Homes (FGHs). In each establishment, a Housemother was recruited and provided with accommodation for her family and for families of children who would otherwise be cared for in large residential homes. The

Housemother's husband, though not employed, was expected to assist in the care of the children. Jersey set up FGHs at a time when this model was falling out of favour elsewhere. While the intention of keeping families together was commendable, appointments of untrained staff, inadequate supervision of the establishments and unrealistic expectations of the Houseparents' abilities to blend and meet the needs of their own and other families meant that failure of the model was inevitable. Children admitted to these establishments endured an unwelcome dilution of ties with their birth families, and some were trapped in settings with abusive carers, with little access to outside assistance.

3.7 HDLG's remand function had ceased in 1979, with the opening of Les Chênes, an educational residential establishment. Les Chênes was intended to have both care and educational staff to address the significant needs of young people with histories of offending. In fact, it was staffed entirely by teachers. A secure unit was built at the request of the Principal, Tom McKeon. The Inquiry heard evidence of children being routinely placed in secure accommodation on admission to Les Chênes. While the rate of admission to Les Chênes was, in some periods, comparable to admission rates of youth offenders in other jurisdictions, the evidence before the Inquiry suggests that the thresholds for admission in Jersey were much lower. Offences that would have merited non-residential disposals or that would have been diverted from court in other jurisdictions resulted, in Jersey, in admission to care. Children admitted to Les Chênes on welfare grounds experienced a similar regime to that for young people remanded by the courts. Some Magistrates ordered repeated remands of young people, meaning that they were, in effect, serving sentences at Les Chênes. A report in 2001 from Dr Kathie Bull was critical of nearly all aspects of Les Chênes. In 2003, there was another damning report, by Madeleine Davies, as a result of an unannounced inspection.

Foster care

3.8 Jersey identified at an early stage the need for foster care as an additional resource for the needs of children who could not stay in their own families. We heard many examples of children who experienced stability and loving nurture in foster homes. We also heard accounts of children who suffered abuse,

emotional cruelty and neglect at the hands of unsuitable foster carers. Jersey's policy and practice in relation to the assessment and vetting of foster carers for decades lagged behind accepted good practice in the rest of the developed world, relying on minimal scrutiny and local knowledge.

3.9 We heard of the persisting challenges of recruiting foster carers in an island with housing shortages, where many people do not have the space to take in another child and where high living costs mean that all the adults in households generally are in full-time employment. Back in 1977, the proposal was made to professionalise foster care by paying one member of the household a salary to stay at home and support a vulnerable child. Forty years later, despite repeated efforts, this elsewhere commonplace approach has not been implemented in Jersey. There has been a provision for dedicated foster care social workers in Jersey since 1982. Current foster carers, however, painted a disheartening picture of insufficient support, guidance and training for foster carers, and an administrative system that they feel disempowers them and does not value their knowledge of the children who live with them. We heard that several foster carers have ceased fostering because of exhaustion and frustration with the system.

Decisions to admit children to care and discharge from care

3.10 While our remit is to look at residential care, when considering admissions to care it has been essential to consider the principles, policies and professional practices that inform the decisions that led to children coming into the care system. For many decades, social work practice in Jersey has failed to develop standards and processes commonplace in other parts of the world. We heard evidence about serious case reviews (SCRs) conducted in recent years, which identified ongoing poor assessment practice and missed opportunities to remove children from harmful environments, failures to react to children's complaints and staff with insufficient skills working under inadequate management oversight in the area of child protection. Poor practice leads to poor decisions about children and their needs.

3.11 Although the legislative bases for taking children into care were widely drafted, we consider that some children were received into care without a

lawful basis. It follows that their rights as children were disregarded. We consider that public authorities in Jersey have had a long history of giving insufficient regard to the law in relation to children.

3.12 We noted, for example, that, during Mario Lundy's term of office at Les Chênes, a policy was adopted that allowed a child to be admitted for long-term stay on the imposition of a probation order with a condition of residence at Les Chênes. We found this approach to be seriously flawed and a distortion of the purpose of a probation order, which is to assist and support young people in the community. We also found that the Education Committee did not exercise proper oversight with regard to such placements.

3.13 It is clear to us that, in the 1940s and 1950s, there was no real expectation that a child in Jersey, once admitted into care, would ever leave the care system. No doubt for that reason, there was no specific provision in law for the return of children to their birth families, although this does appear to have happened on occasion.

3.14 It is clear that, at least up to the mid-1980s and the closure of HDLG, the placement of children in residential facilities reflected the availability of such places on the island and the lack of alternatives, such as preventative work or placement with foster or adoptive families, rather than the assessed needs of the children concerned. Whether those needs were best met in a residential facility does not appear to have been a consideration at this time.

3.15 There was no consistency in the approach taken when considering whether the child's circumstances justified removal from the family home. For example, there were cases when the justification for removal of a child from their family and placement in a care institution was that the child had *"behaviour problems"*, such as being involved in *"petty pilfering",* or was said to be *"rude and cheeky"*. Such a draconian intervention paid no regard to the rights and needs of the child.

3.16 Until the late 1980s, there was no system for providing parents with assistance in the home, which could have avoided the need for removal; a parent who sought assistance from the Parish was subject to the unregulated

judgement of the Connétable. There was not, as was noted by Lambert and Wilkinson in 1981, and there is still not, 36 years later, a statutory provision in Jersey for carrying out preventative child care. While the *Children and Young Persons Act 1963* in England and Wales allowed for expenditure to prevent a child from being admitted into care, in Jersey, children were received into care for short periods, when they could, with financial or other assistance, more appropriately have remained in their own homes. The existence of a statutory duty for the carrying out of preventative child care might well have removed the need for taking some children into care.

3.17 We found that, in Jersey, the approach to child care has been generally reactive, with no considered criteria for admission into residential care for many decades. There was also, for decades, no adequate review of placements, and much of the time the wishes of the child were not sought. There was a pattern of maintaining children in residential homes for an excessively long period. There was no coherent model of intervention, and no consideration of what therapeutic work was necessary to enable a child to return home.

3.18 We considered that the mechanism for discharging a child from care was thoroughly inadequate. Although the States of Jersey had the legislative power to discharge children from care when it was in the best interests of the child, at least up to the late 1980s/early 1990s, there does not appear to have been any system for proactive consideration of this: the child was effectively abandoned in the care system. When a child left the care system in their mid-teens, they were often again abandoned without adequate aftercare to make their own way in the world. In such circumstances, young people succumbed to exploitation, addiction, crime and depression. A few who went on to build careers attributed their survival and success to fierce personal determination and often the support of a concerned adult, a teacher, child care officer or family friend.

Summary: state intervention and state indifference

3.19 In summary, we have found a worrying history of both inappropriate and ineffectual state intervention and state indifference. Children have, at times,

been removed from families without a statutory basis or for seemingly inconsequential reasons. Child care legislation in Jersey has failed to keep pace with developments in social care and children's rights in the developed world. Historically, there has been insufficient regard to the needs and rights of children at risk. There has been insufficient clarity about assessment or thresholds for intervention, with the result that some children may still come into care unnecessarily and others may remain in harmful environments. Admissions to care have often been arranged without consideration of the outcomes that the care period should achieve and, until recent times, how long it should last.

3.20 For many years, once a child was in a residential establishment, little effort was made to determine how they were coping in that environment, or of how it was affecting them. Aftercare of looked after children has been inadequate. Significantly, there has been little evidence in Jersey of political initiatives to tackle the underlying causes of the social problems known to render children vulnerable to care admission, including child poverty, addiction, inadequate housing, mental health problems and social isolation.

How Jersey's homes operated: key events and notable findings

4.1 Term of Reference 2 requires us to determine the organisation (including recruitment and supervision of staff), management, governance and culture of children's homes in which abuse has been alleged, over the relevant period, and to consider whether these aspects of these establishments were adequate. Chapter 4 of the Report sets out, in detail, key events and findings in full.

4.2 In this summary, we describe briefly the most notable findings in relation to each establishment. In all, we have made over 100 findings in relation to the operation of various institutions. Some findings, such as those in relation to standards of care and use of secure accommodation, are applicable to more than one home. We consider these briefly, then move on to look at individual homes.

4.3 We found that there has long been in Jersey an absence of political and professional will to set or monitor standards of care, including aftercare, or to prioritise resourcing the care of the children for whom the state had parental responsibility. Between the 1940s and early 1970s, the States appeared to take little responsibility for ensuring that there were adequate standards of care in voluntary homes, including homes in which it placed children. In earlier decades, there were occasional invited inspections of States' care homes by UK Home Office experts, but these had ceased by the 1970s and no form of internal inspection replaced them. For the remainder of the period in which the homes operated there were only rare external reviews. For example, in 1981 Inspectors David Lambert and Elizabeth Wilkinson, from England, carried out an inspection the findings of which we make reference to throughout our Report. Their recommendations included that HDLG be closed, that provision for residential care be re-assessed and that resources for preventative care be increased. As with later reports by Dr Kathie Bull and Andrew Williamson, significant recommendations were not implemented. We noted also that, for decades, residential staff and field social workers appeared to work in separate silos instead of combining forces and resources to secure the best outcomes for children.

4.4 From the perspective of many former residents, the awareness or the use of secure accommodation or detention rooms has been a significant feature of their care experience. We have made detailed findings in respect of the use of detention rooms/secure accommodation in various establishments. Throughout the period reviewed, secure rooms were not used in other Western nations, save for the most serious of circumstances, and only as a means of last resort and for the minimum necessary time. For example, by the early 1980s, the use of secure accommodation in homes in the UK was subject to strict regulation, and each confinement required the approval of a senior member of the local authority. There was daily review of the necessity for secure confinement, and regular assessment of the child by a medical practitioner. Secure rooms were never used to punish or control children. In general, we found that, in Jersey, such facilities were used routinely and

excessively, in a punitive fashion, without regard to the needs, welfare or rights of the child and without proper care or safeguards.

Jersey Home for Boys and Jersey Home for Girls

4.5 In the late 1950s, Jersey's children homes were operating under rules drafted in 1924. In this period there was no regulation of punishments in care homes. Various records from the punishment books refer to strappings and public punishment. We heard, however, many accounts of cruel and degrading punishments, such as children being humiliated and beaten with nettles for bedwetting, or being locked in confined spaces. Many examples are provided in the Report and in the brief histories of people in the care system at Appendix 2. Even by the standards of the time, the approach to punishment in Jersey homes in the 1940s and 1950s was inappropriate, and we find the management and oversight of the homes to have been deficient in this regard.

4.6 We considered evidence about bullying and child-on-child sexual abuse, both of which are substantiated by records in the punishment books. Other than by the use of corporal punishment, we saw no evidence of these issues being tackled. Although, in hindsight, we consider this to have been unsatisfactory, the approach taken is likely to have been in accordance with the standards of the time.

4.7 It would appear that qualifications or training were not a requirement for persons being recruited to senior roles at the homes, and that no training or supervision was given to persons caring for large numbers of children, many of whom had significant emotional needs, having experienced trauma, bereavement, abuse or neglect. Even though the culture of JHFB and JHFG changed over the relevant period, as staff changed, the regimes remained harsh and strictly regimented and the suffering of the children who were sent there did not diminish.

Sacré Coeur

4.8 Most of the evidence we heard was from former residents, and we can only consider the management and operation of the institution by the impact of the regime on the children placed at Sacré Coeur. As early as 1964, concerns

were raised by the Children's Officer about *"emotional deprivation"* experienced by children at Sacré Coeur.

4.9 The majority of witnesses describe a harsh and strict regime, with frequent physical, frightening or humiliating punishments for breaking rules. Some witnesses consider that the regime, while strict, was not abusive. We find, however, that the preponderance of the evidence justifies the conclusion that the regime at Sacré Coeur was abusive, with the emphasis on rigid discipline rather than on nurture. This is so even taking into account the standards of the time.

4.10 We found that while the industrial model of training residents of working age in factories existed elsewhere, it continued much longer in Jersey. Notably, even young children at Sacré Coeur contributed to the work and output of the Summerland garment factory.

4.11 Sacré Coeur was a well-known institution on the island, accommodating a large number of children who were seen selling produce and collecting money. Such an institution, and the welfare of its children, should have been of interest and concern to the public authority. It was not adequate in that, as of May 1958, there were 66 children resident at the Orphanage without any public supervision or inspection. We have seen evidence of only one visit by the Children's Officer, in 1964. We consider that the States of Jersey should have taken greater responsibility for ensuring that these children were adequately cared for. Given that the authorities had powers in this period with regard to children who were privately fostered, we do not accept that the state was powerless in relation to the large number of children admitted to the Orphanage.

<u>Haut de la Garenne</u>

4.12 The organisation (including recruitment and supervision of staff), management, governance and culture of Haut de la Garenne in the entire period under review (1945–1986) was far from adequate, even when measured by the standards of the day. As early as 1946, such large-scale institutions were deprecated in the 1946 Curtis Report in the UK.

4.13 The mix of ability and experience among recruited staff was wide ranging and seemingly unrelated to their role as carers at the Home. Staff were ill equipped to deal with the behavioural and emotional needs of children placed in the Home. We found recurring examples of the overseeing political committee preferring to recruit inexperienced people from within the island than outsiders who may have been better qualified. Problems were compounded by there being little, if any, staff training. The situation was exacerbated in some periods by a particularly unfortunate and toxic mix of personalities in the staff group, who practised or tolerated harsh treatment of children unchecked, failed to engage with them and devoted attention to staff social activities. WN870 commented: *"I have never witnessed a children's home run quite like Haut de La Garenne where children were not their priority."* WN532, a staff member in the 1970s, described HDLG as *"a workhouse environment and run with a degree of military precision which seemed to exclude the appropriate element of care and best practice for the children".*

Heathfield

4.14 In common with those at other establishments, Heathfield staff do not appear to have had sufficient training for their role. Some staff were appointed without basic qualifications. However, recruitment of staff from the beginning of the Home's existence did involve police checks. While some innovative practices were initiated at Heathfield, by 2005, a litany of concerns had been raised about the operation of the Home. We found the management response inappropriate and lacking insight, including Kevin Parr-Burman's response of blaming the young people for not engaging rather than his taking responsibility for the operation of the Home, and Joe Kennedy's response of emphasising the necessity of control as opposed to care.

La Preference

4.15 In the early stages of La Preference, from the 1950s, the lack of interest shown in the Home by Children's Services is concerning, given that they were placing children in the Home. No concern was ever raised that children admitted to La Preference had to adopt a vegetarian diet. During the period

from 1971 to 1983, the evidence suggests that the Home generally had a family atmosphere and a more relaxed environment than other institutions in Jersey. We consider that this is largely due to the positive effect that Christine Wilson had on the culture of the Home. The States took over the Home in 1984. By the early 2000s, its organisation and management had deteriorated and there was insufficient funding, overcrowding and inadequate staffing levels. Staff were insufficiently skilled or trained, despite their commitment and efforts to foster good relationships with children. At times, children were sleeping in the living room due to overcrowding. In the 21st century, this is a completely unacceptable way for a state to accommodate children in its care.

Brig-y-Don

4.16 Brig-y-Don (BYD) succeeded as a voluntary children's home largely because of the leadership of Margaret Holley, who kept up with child care practice elsewhere and maintained a high staff-to-child ratio. In the late 1980s and early 1990s, the Home was at the forefront of shared care, outreach and key worker schemes, which helped to focus on the individual needs of children and promote close contact between children and their families. WN503's recruitment helped to drive progress in developing child care practice at the Home. The ethos of the Home was described as warm and friendly, and staff turnover was low. Staff received supervision and attended training sessions. Children's rights to complain were acknowledged and supported. The Brig-y-Don Committee provided proper oversight of the establishment.

4.17 Notwithstanding the nurturing environment, the States' practice of placing young children under four years of age in residential care at BYD up to and during the 2000s was significantly out of step with practice in other jurisdictions. We found States involvement in the governance of BYD to be adequate while it was a Voluntary Home but, once the States took over the management of the Home, it became an entirely different institution. Between 2012 and 2014, the management and organisation of the Home was not adequate. In 2013, the Board of Visitors were *"very concerned"* about the situation at the Home, noting that it had "*the character of a turbulent children's*

home". A change in management occurred in 2014, leading to some improvements.

Family Group Homes

General

4.18 The rationale for setting up FGHs in the late 1950s/early 1960s was to move children from large institutions into smaller, more homely settings. This was an appropriate policy to have adopted. By the early 1970s, however, the concept of the FGH was being abandoned across the UK as unworkable. Jersey, however, continued to expand a model that was characterised by poor oversight and unsuitable, inadequately trained or poorly supervised staff, which led to children suffering abuse or failing to receive nurturing care.

4.19 We found evidence that the intended arrangements for support and oversight of FGHs were inadequate. The expectations placed on the Houseparents were too onerous and there was an inadequate system of expecting the Housefather to look after the children without being employed by, or accountable to, Children's Services. Despite Home Office recommendations in 1970, there appears to have been little professional development for staff in the FGHs. Some Children's Service staff became overly familiar with the Houseparents and failed to exercise impartial professional oversight. Visits by child care officers (CCOs) were irregular and ad hoc visits by the Children's Officer insufficient. In an island as small as Jersey, this is inexcusable and inexplicable. There was insufficient attention paid to maintaining children's links with members of their birth family. Indeed, on the evidence available to the Inquiry, in some of the FGHs, those links were positively discouraged.

Clos des Sables

4.20 The management and organisation of Clos des Sables was inadequate. Janet Hughes described herself having "*reached a stage of near breakdown"*, after finding the role of Housemother too difficult almost from the very beginning. The FGH model was fundamentally flawed because the Home had the number of residents of a small children's home but the staffing structure of a foster home. This required Mrs Hughes' husband, Les Hughes, to provide

care for vulnerable children in the care of the States of Jersey. He was effectively carrying out the role of foster parent to a large number of children, without vetting, training or supervision. This proved to have dreadful consequences for children living at Clos des Sables.

4.21 Evidence on the culture of the Home is mixed, with witnesses noting the frugality of food available to the children and some noting locks on cupboards and the fridge. On the other hand, Marnie Baudains thought that the Home had quite a pleasant feel. The fact that, for most of the Home's existence, children were being sexually abused in a relatively small environment is indicative of how little was understood by Children's Services about the children's living conditions. Although CCOs visited fairly regularly, senior staff, including Brenda Chappell and Charles Smith, largely left the Hughes to their own devices. We note the work of Marnie Baudains that contributed to disclosures of abuse, and the response by her and by SOJP once matters came to light.

FGH run by WN279 and WN281

4.22 In line with the other FGHs, the staff and the Houseparents did not receive any training, or any guidance as to acceptable forms of discipline. The evidence we received on the culture of the Home was mixed. For at least some of the residents, there was a tense and controlling atmosphere, in which the children in care were spoken to and disciplined harshly and did not have their emotional needs looked after. WN279 said that, at the time, a group of the children were *"persistent liars",* and this sort of disdain appears to have influenced the culture of the Home. One witness referred to it as a *"reign of terror"* and the contemporaneous records suggest that the ability of the children to speak out was limited. On the other hand, other adults spoke positively about their time at the Home.

4.23 We consider that the oversight of the Home was largely inadequate. Although there were regular visits by CCOs nothing appears to have been done about the reports of one CCO, Ms Hogan, in 1975 that were critical of the culture of the Home. Furthermore, the allegations of physical abuse that were raised in

1975 and 1977 against WN279 were inadequately handled by senior managers and failed the children concerned.

Norcott Villa

4.24 Early in the history of Norcott Villa, the employment of the Housemother, WN791, was terminated following adverse reports about the care of the children. The decisive action of the Children's Sub-Committee in this respect contrasts with the handling of allegations at other FGHs. The events did not lead to more robust oversight of other FGHs. We note that subsequent houseparents at Norcott Villa, though strict, appeared to have better insight into the needs of the children.

Blanche Pierre

4.25 The operation of Blanche Pierre was a testimony to the failure of States' management and oversight of the Home. Shamefully, the problems of Jane and Alan Maguire were blamed on the children, at least one of whom was sent away and separated from siblings. Certain children were scapegoated and the Maguires' accounts were sometimes accepted uncritically by social work staff. Within the Home, Jane Maguire tried to prevent other staff from establishing a rapport with the children. She limited the children's contact with their friends and families, which in turn affected their opportunities to tell a trusted adult about the conditions in the Home. The Maguires' approach to the issue of bedwetting was inexcusable: Jane and Alan Maguire subjected the children to humiliating and degrading treatment.

4.26 The culture of the Home was oppressive and fearful. Jane and Alan Maguire created a punitive regime in which certain children were terrorised and abused. As reported by the former residents and corroborated by the Home Diaries, the daily routine was punctuated with harsh punishments that included beatings, washing of mouths with soap, and making children stand in one place for prolonged periods. We consider that the evidence of one staff member, and of some children, which suggested a more positive regime did not represent the reality of life at Blanche Pierre, certainly by the late 1980s.

4.27 As far back as 1987–1988, CCOs were recording Jane Maguire's inability to cope and her resistance to outside intervention, yet nothing was done to address this. Brenda Chappell's friendship with Jane Maguire was unprofessional in that it prevented her from undertaking proper objective scrutiny of the establishment and so failed to safeguard the residents of Blanche Pierre. Concerns raised by CCOs about the Maguires were not heeded at a higher level.

4.28 There is no evidence that the Home Diaries were ever inspected: had they been, the abuses perpetrated by Jane and Alan Maguire would have been identified much earlier. We find it astonishing that at Blanche Pierre such a record of flagrantly abusive punishments was maintained and available for inspection.

Les Chênes

4.29 Les Chênes opened in 1977, combining an Approved School ethos with a remand centre. We find this to have been a flawed model from its inception. Elsewhere, such establishments were seen as being no longer viable. John Pilling, who undertook a review of Les Chênes in 1980, suggested that the management model of Les Chênes existed more to meet staff needs than children's needs.

4.30 We note that Les Chênes did provide a high quality of specialised education, as described by Lambert and Wilkinson in 1981, which was valued by some residents.

4.31 We consider the decision, taken at the outset, to run Les Chenes with teaching staff alone, rather than a mix of care and teaching staff, to have been flawed and that it adversely influenced the ethos and operation of Les Chênes. We find the practice of denying home visits to children, sometimes for weeks, unacceptable even by the standards of the time, and we see no justification for it. We find unacceptable the practice of routinely placing children in a secure room, whether admitted on remand or for welfare placements. This was an objectionable and ill-informed approach to child care

management. We do not accept the evidence of Mr McKeon and Mr Lundy on the frequency with which secure accommodation was used.

4.32 We conclude that under both Tom McKeon and Mario Lundy, Les Chênes was managed in a strict and physically dominant way. The culture and ethos of Les Chênes were akin to the outdated model of an Approved School. Much of the culture of Les Chênes was determined by the personality and presence of Mario Lundy: his was a physical and robust approach informed by his own vision of how the school should function and what its goals should be, rather than recognised best practice in care. We also note the number of allegations of physical abuse that relate to this period.

4.33 We consider that the heavily structured and physical regime of Les Chênes combined with a staff group unequipped to provide social care and untrained in the use of physical restraint, gave rise to inconsistent and at times excessive use of force by adults towards children. We find this to be a failure of management by Mr McKeon and Mr Lundy.

4.34 The problems that Les Chênes faced were compounded by the practice of Magistrates from the late 1990s to remand significant numbers of children at Les Chênes, often repeatedly. The approach of Magistrate Le Marquand reflected an attitude on the island, reflected in the view of the Chair of the Les Chênes Governors, that the place was full of *"little villains"*. We are under no illusion as to the management issues, particularly those posed by individual young people placed on remand at Les Chênes at this time, but we consider that there was a failure of agencies – the school, the Director of Education, the Probation Service, Children's Services and the courts – to work together constructively and decisively to assess and plan to address the needs of individual children.

4.35 Instead, several young people experienced a revolving-door existence of remand-release-offend-remand, up to 17 times, with no effective intervention to tackle the roots of their offending behaviour. We have noted many examples of young people who suffered because of this failed approach; the repeated detention of WN72 in the secure suite over a long period, for example, was ultimately a serious failure of management.

4.36 In her review of Les Chênes, Dr Kathie Bull noted that the problems of over-crowding; hot-bedding and mixing welfare and remand were already evident from 1997. We consider that the comprehensive failings identified by Dr Bull, relating to all aspects of the running and management of Les Chênes, are failings that should have been identified earlier.

4.37 We heard from Ron McLean, who, from 1997 to 2009, chaired the Les Chênes Board of Governors, which later became the Greenfields Board of Governors. There was no interview for appointment to the Boards and the only criterion was that members were of "good standing". Mr McLean visited Les Chênes every week but he did not speak to residents on their own, nor did he ask to see the secure unit logs. The Governors reported to the Director of Education but, according to Mr McLean, they *"very, very rarely met with him"*. He said that they relied on the Principal to tell them *"if the needs of the residents were being met"* and *"if we were told everything was fine, just accepted that"*. Dr Kathie Bull suggested that the Governors were aware of concerns about Les Chênes over a long period of time, but did nothing about them. This included locking children up using what she described as *"legally dubious methods"*. We conclude that the Director of Education, the Education Committee and the Board of Governors at Les Chênes failed to exercise proper oversight during this period. We consider this a significant and inexcusable failing of governance.

4.38 We find that the management of Les Chênes under Kevin Mansell fell substantially below an adequate standard. We attribute the failure in management in large part to circumstances beyond the control of Kevin Mansell and his staff, although their response to the pressures that they were under also falls to be criticised. Notwithstanding the assault and distressing threats to which Mr Mansell and his family were exposed in 2001, and the enormous pressure that he and his staff were under, we find that Kevin Mansell failed to manage his own staff. This pressure resulted in poor decision making – for instance, keeping children in secure cells while having staff meetings – as well as to over-reaction in the use of restraint and the indiscriminate use of the secure facility.

4.39 We find that, in that period, Kevin Mansell and his staff were poorly supported by Tom McKeon, then Director of Education, who appears to have distanced himself from Les Chênes in the same period. We find that his evidence to the Inquiry about this period reflected his view that Les Chênes had lost its purpose and way. We conclude that the Education Department failed, in allowing the establishment to flounder, to the detriment of the children for whom it was caring.

4.40 In our view, the August 2003 "riot" at Les Chênes was in fact a relatively minor incident of disorder that, as a result of poor handling by staff, escalated out of all proportion. Once the situation began to deteriorate, the shift leader should have called the Acting Principal, Peter Waggott, before he called the Police. The presence and deployment of the Police rapid response team simply exacerbated the situation.

4.41 In summary, the ethos of Les Chênes was one of containment and control rather than any therapeutic focus or attempt to divert young people from offending. Throughout its existence, the Les Chênes regime was often harsh, inappropriate and unsuited to the needs of children placed there. We have discussed in the Report specific allegations of abuse and the experiences of individual young people. We consider that the determination to have exclusively teaching staff, with no professional social care input, was a factor in the failures of the operation of Les Chênes.

<u>Greenfields</u>

4.42 We endorse the criticisms of Greenfields expressed by the Howard League in 2008. We find that the prison-based "Grand Prix" behaviour management system, as applied at Greenfields between 2003 and 2007, was totally inappropriate.

4.43 We consider that the changes sought to be implemented at Greenfields by Simon Bellwood, when social care staff took over the establishment, were positive and necessary. We echo his sentiments that children in Jersey do not have a voice – or at least not one that is taken seriously or respected.

4.44 The Panel visited Greenfields Centre in 2015. We were concerned about the prison-like nature of the facility and by the regime, as described to us at the time of our visit. We felt that the ethos was one of control and containment. We deprecated the seeming absence of a welfare-based approach. We consider that greater clarity is needed on the purpose of such a facility, which should accommodate only children on remand for the gravest offences. Secure accommodation should be an option rarely used, and then for the least necessary time, when there is no other way of minimising the risk of harm that a young person poses to others. Secure accommodation should never be used as a punishment.

4.45 The Board of Visitors for Greenfields (modelled on the prison visitor system) was formed in 2004, replacing the Governors, but, according to Mr McLean, it amounted to simply changing the name. It was unclear to whom the Visitors were accountable and, as a result, they felt that nobody in the Health and Social Services Department knew they existed. When asked whether the Governors or Board of Visitors had provided effective oversight Mr McLean initially said that they had done a good job, but, on reflection, having given oral evidence to us, he said: *"I don't think we did."*

4.46 In 2008, the Howard League said of Jersey: *"There is far too high a level of custody, and we believe that measures should be taken to eliminate it … thought needs to be given to a more flexible use of Greenfields and a great reduction in its use as a secure facility."* Nine years later, we echo those sentiments. The existence of Greenfields reflects a cultural malaise on the island with regard to young people who have become marginalised; some sections of society see those young people only as problems to be locked out of sight rather than as young citizens to be assisted to overcome their disadvantages and reach their potential.

4.47 In summary, over many decades, there were persistent failures in the governance, management and operation of children's homes in Jersey. Failings were at all levels: there was no political interest in defining and promoting standards of care and performance in residential care and no will to invest the resources required in child care services. Unsuitable people who

were appointed to management roles, often on the basis of local connections, lacked the leadership skills to manage and raise practice standards and had little up-to-date knowledge of child care theory and practice. As a result, ill-suited carers continued to look after children in unsuitable facilities, using outdated practices. The consequences for the children in their care were devastating and, in many instances, lifelong. In Chapter 12, we set out the systemic failures that characterised residential care and the lessons to be learned.

Political and other oversight of children's homes and of fostering

5.1 In Chapter 5, we deal with the political and other oversight of children's homes, fostering services and other establishments run by the States of Jersey, as required by Term of Reference 3. We also deal with the effect that the political and societal environment had on such oversight, including the reporting or non-reporting of abuse and how it was responded to, as required by Term of Reference 4.

5.2 We heard from senior elected members who had held responsibility for Children's Services under the various governance structures that applied at different periods, whether that be the Education Committee Children's Sub Committee (1960–1995), the Health and Social Services Committee (1995–2005) or Ministerial Government from 2006 onwards. While we do not doubt that these politicians were well intentioned, we heard a number of things that caused us concern.

5.3 Keith Barette told us that there was no regular contact between Children's Services and the Children's Sub-Committee. He was a regular visitor to the Home, and it is of concern that staff told him he was the only sub-committee member who spent time there. Patricia Bailhache told us that she believed that the role of the Education Committee was to be supportive of the Children's Officer rather, it seems, than holding them to account. The Sub-Committee was abandoned in 1988, at her suggestion, because it became clear to her that it was achieving little and was not providing any scrutiny.

5.4 Bob Hill said that the Health and Social Services Committee did not provide adequate oversight of children's homes because it was not given enough information to allow it to do so. He also told us that, in his view, the Committee tended to focus on health rather than social services issues. Paul Le Claire told us that it was deemed inappropriate to speak out of harmony with other committee members and that the minute-taker would be asked not to record certain points, usually when something controversial was raised. He said that, on reflection, he thought that the Committee had insufficient oversight.

5.5 Ben Shenton was Minister for Health and Social Services between 2007 and 2009. He said that the role of politicians was to implement the policies of the States of Jersey, whereas we would have assumed that the role of the Minister was to shape those policies. In his view, progress in Jersey depends on moving within establishment circles. His view was that his predecessor as Minister, Senator Syvret, had been removed from office because he was too outspoken and challenged things publicly. In 2008, Mr Shenton wrote to the Chief Minister, setting out his concerns that the Children's Services Department was not fit for purpose and that there were difficulties with accountability and because departments were operating in silos. He was succeeded as Minister by Deputy Anne Pryke, who told us that politicians set policy and it was the duty of line managers to implement it and to support staff. She did not, however, recall anything being put in place to check whether policy was in fact implemented.

5.6 We consider that the level of oversight of children's homes by the Education Committee and its successors was inadequate. The various committees and their professional officers failed to formulate adequate policy or legislation. While we acknowledge that some delays in legislating would be explicable for administrative reasons, as Mrs Bailhache set out, we can see no good reason why the *Children (Jersey) Law 1969* was passed over 20 years after its English counterpart, and the *Children (Jersey) Law 2002* passed over 10 years after its counterpart.

5.7 We find that, from the late 1970s, the Children's Sub Committee was largely ineffective in carrying out any oversight. Children's Services were undoubtedly

the “poor relation” of the Department in which they were located, whether that was Education or Health. In our view, members of the Committee had a responsibility to lobby for greater importance to be accorded to Children’s Services, but we see little evidence that they did.

5.8 The Education Committee, including the Children’s Sub-Committee, failed to properly carry out its role as a “critical friend” of Children’s Services and did not take adequate steps to ensure that the children for whom they had a statutory responsibility were being suitably cared for. There was a lack of understanding about what their role should have entailed and what oversight actually meant.

5.9 Part of this oversight role should have included the commissioning of external inspections – something that was not even considered by Mrs Bailhache in her role as Chairman of the Children’s Sub-Committee. In fact, there was no external inspection of children’s homes or children’s services for approximately 20 years, between the Lambert and Wilkinson Report in 1981 and the first report of Dr Bull in 2001. This is particularly concerning given that there were significant allegations of abuse in three different children’s homes between 1989 and 1991 that were known to Children’s Services, yet there was no review and no inspection, and no difficult questions were asked. This was unacceptable and a further example of inadequate political oversight.

5.10 During the period in which the Health and Social Services Committee was responsible for oversight, they appear to have taken a passive role, in which there was very little discussion of children in care. Oversight was inadequate and even if members were insufficiently informed to ask relevant questions of Children’s Services officers, they had a responsibility proactively to seek that information.

5.11 We find that the corporate parent system largely failed because, as Deputy Pryke described to us, no one person or department wanted to take responsibility for anything. While, in more recent times, many reports were commissioned concerning children in care, there was nonetheless a failure to respond adequately to recommendations. We find it to be deplorable that the States of Jersey has failed to understand its role as corporate parent and that

Children's Services, and thereby the island's most vulnerable children, were not given sufficient priority in government time, funding and attention.

5.12 We find that the Board of Governors for Les Chênes and the Board of Visitors for Greenfields did not carry out effective oversight of the way in which these institutions were run and, as such, they failed the children who were placed there. They also failed to lobby for adequate resources, not least when there were concerns about overcrowding. This was, in our view, an inadequate discharge of their role.

5.13 In relation to fostering services, we find the lack of legislative regulation of the fostering of children in care until 1970 to be unacceptable. The Children's Officer was wrong to assert, in 1979, that the Children's Department had a *"minimal role to play"* in private fostering, whereas in fact there was an explicit duty under *Article 57 of the 1969 Law* to "satisfy themselves as to the well-being of the children". The level of boarding-out allowances in Jersey was consistently too low to attract a sufficient number of suitable foster parents, particularly when coupled with the social pressures specific to Jersey, such as high housing costs. It was inadequate that a Fostering Panel was not set up until 2001 and as such this was contrary to good practice that had long been established in the developed world.

5.14 We found that there remains a lack of support, guidance and training for foster parents, and that communication between them and Children's Services is inadequate.

5.15 In regard to Children's Services' oversight and operation, we looked in detail at their history and operation. It was not until 1958 that the first Children's Officer in Jersey, Patricia Thornton, was appointed. This was 10 years after the creation of such posts under the *Children Act 1948* in England. Between 1984 and 1986, the post of Children's Officer was held by Terry Strettle who had previously worked in England. An article on his leaving said that *"the one major change that Terry Strettle had brought to Jersey was the concept of a move away from children in care to children in the community … living with their families".*

5.16 Anton Skinner was appointed Children's Officer in 1986, when Terry Strettle's short-term appointment ended. We heard detailed evidence of structural changes that Mr Skinner and his successors initiated in Children's Services between 1986 and the 2000s. These are set out in detail in Chapter 5, as are the findings of the various reports that were commissioned during this period.

5.17 We consider that in Jersey there has been no political appetite for addressing social issues concerning the welfare of children. The focus has been on structure and process, with little consideration given to the necessary quality of leadership, the performance of staff or the experience of children in the system. We find that leadership generally has been lacking, and that the focus in Jersey has instead been on administration and hierarchy.

5.18 We note the many reports on the problems in child care services that have been commissioned over the years. While some recommendations have been implemented, we find that many, including some of significance, have not. Costs and prioritisation seem to have been constant issues holding back progress. There has been, for many years, a failure to adopt a strategic approach and to develop policies to meet the needs of children and young people in Jersey.

5.19 A key factor in these failings has been that Jersey has struggled to recruit and retain senior social work staff. As a result, the practice has been to promote existing staff who have sometimes lacked the necessary leadership qualities and senior management skills. In saying this, we do not doubt the commitment and dedication of these individuals in their front line roles.

5.20 Another major factor in the failure of the child care system has been that, since 1945, Jersey has become disconnected from mainstream social care developments and practice elsewhere in the world. It is our view, echoed by some witnesses, that because Jersey has not known *"what good looks like"*, the island has not been able to deliver services that were fit for the purpose of looking after vulnerable children.

5.21 We note that while child protection guidelines were initially published in 1991 and revised a number of times subsequently, producing documentation does

not keep children safe. Within Children's Services there was little investment over the next 20 years in equipping staff to implement the guidelines effectively.

Changes in and development of child care practice from 1945

6.1 Chapter 6 of the Report deals with changes in child care practice over the years and reflects the report prepared for the Inquiry by Professors Bullock and Parker. It links with the report prepared by Richard Whitehead, who conducted a review of child care legislation in Jersey from 1945. This allows for comparison between developments in Jersey and those in the UK. These reports deal with Term of Reference 5, which asks for a chronology of significant changes in child care practice and policy. A summary chronology of key events also is included at Appendix 1.

6.2 The development of child care legislation in Jersey has been influenced and modelled on UK legislation, and in particular that pertaining to England and Wales. The introduction of legislation in the island tends to be behind that of the UK, often by many years. The *Children (Jersey) Law 1969* mirrored the UK's *Children Act 1948*, for instance.

6.3 Richard Whitehead said that in the very small jurisdiction of Jersey *"some major changes just take a long time because there are not many people working on them"*. Former Minister Ian Le Marquand said, however, that the priority for the States and the electorate was (and remains), the maintenance of the low tax status on the island. Chief Minister Senator Ian Gorst told us that it was not fair to suggest that financial legislation received greater priority than child care legislation. Others with experience of the political system disagreed. Wendy Kinnard, the former Home Affairs Minister, told us, however, that legislation relating to the finance industry would "definitely" take priority due to the influence of outside agencies such as the IMF. Similarly Deputy Higgins thought that legislation relating to financial regulation was certainly *"top of the pile"*.

6.4 We consider that the delays in Jersey in adopting good practice and legislation informed by modern thinking can be explained only by a lack of

political and professional will. Traditionally, the wellbeing of vulnerable children has been low on the list of Jersey's priorities for legislative change and development. We find that to be unacceptable.

Experience of witnesses

7.1 Term of Reference 7 requires us to consider the experience of those witnesses who suffered abuse or believe they suffered abuse.

7.2 We considered allegations of abuse across residential homes of all types and in foster care. Our consideration included abuse alleged to have been perpetrated by staff, foster carers and other residents and by others including visitors to the homes.

7.3 It was not part of our function to make findings of fact about individual cases but rather to consider whether there were cultures in which abuse was permitted to flourish and whether steps were taken to deal with it when it occurred. We make findings on these issues across other chapters of the Report.

7.4 Personal experiences of Jersey's care system are at the heart of this Inquiry. We heard many lengthy and distressing histories in the course of the evidence. A brief summary of the evidence that we heard about individual experiences is set out in Appendix 2. These short accounts are not intended to encompass the full extent and nature of the histories we heard. They do, however, give an insight into the lives of children in Jersey's care system from the 1940s to the 2000s and highlight the degree and nature of abuse that many suffered. We pay tribute to the courage of all those who shared their childhood experiences with the Inquiry.

7.5 We find that, on the large amount of evidence before us, there can be no doubt that many instances of physical and sexual abuse and of emotional neglect were suffered by children in the care of the States of Jersey throughout the period of review. That abuse and neglect has had far reaching consequences for many of them throughout their adult lives.

Reporting of abuse

8.1 In Chapter 8, we deal with the reporting of abuse, as required by Term of Reference 8, which asks us to identify how and by what means concerns about abuse were raised and how and to whom they were reported. We are asked to establish whether systems existed to allow children and others to raise concerns and safeguard their wellbeing, whether these systems were adequate, and any failings they had.

8.2 Until the 1990s, there is no evidence of a system for victims to report abuse. In the Report we detail and consider many instances of abuse of all types over the whole period of our review, across all forms of care settings in Jersey and analyse the reporting of abuse in each of them.

8.3 It is important to acknowledge how inordinately difficult it is for a child, especially a child with little experience of a loving and nurturing family life, to express concerns about their treatment, let alone find adults who take them seriously. We found that concerns about abuse had been raised by children as well as by their friends, relatives and teachers, CCOs and residential care staff. These matters had been reported to a variety of people, including Children's Services and the Police.

8.4 The creation of Childline in the UK in 1986 did provide an outlet for some children in Jersey to report abuse, but this did not constitute a suitably comprehensive system for children in care in the island. As with other elements of the care system in Jersey, policies and procedures on complaints by children were decades behind those operating elsewhere. By 2005, a formal system for complaints was in place. The existence of a procedure alone, however, is insufficient evidence of its efficacy or of the extent to which children knew about or had confidence in it. One procedure we saw required a child to talk with the head of the home if they wanted to arrange to see an independent person. This was a potentially daunting process for a child with worries about mistreatment. Further, we heard that Children's Services staff were not trained or always made aware of complaints systems and procedures for children in place by the early 2000s. In summary, children in the care system in Jersey have been powerless for decades and it is to our

dismay that we so often found that their accounts went unheard or were discounted when they ventured to express their worries.

8.5 Many witnesses told us that, as children, they did not feel able to report abuse because they felt that they would not be believed. Sadly, some children did not recognise their care as abusive and accepted it as a normal part of life; others were only able to speak of their abusive experiences years later in their adult life; for some former residents, the experience of becoming a parent triggered a reaction about how they had been treated as children.

8.6 It is our conclusion that attitudes in Jersey towards vulnerable children influenced for many years how children in the care system were treated, including how allegations about mistreatment were handled. Over part of the review period, Jersey society remained patrician and hierarchical, and children in care were marginalised. Such attitudes made it more likely that children would not be believed, and contributed to their fear of coming forward.

Response of Education, Health and Social Services to concerns about abuse

9.1 Term of Reference 10 requires us to consider how the Education, Health and Social Services Departments dealt with concerns about alleged abuse, what action they took, whether these actions were in line with the policies and procedure of the day and whether those policies and procedures were adequate.

9.2 We considered homes, fostering services and individual cases and have made findings where we consider it appropriate. These are set out in considerable detail in the Report. We have also included the responses of witnesses to allegations of abuse that were made against them or others. Where we are able to make findings, these are in the main that the responses to allegations of abuse were inadequate. In this summary we highlight a few notable cases.

9.3 A large number of former residents of HDLG gave evidence to the Inquiry or to the SOJP about Morag Jordan and her harsh treatment of children. The weight of evidence and the fact of her criminal conviction demonstrate that

she picked on, bullied and assaulted residents. Several staff members reported having seen her assault children, and a small number say that they reported her to the Superintendent of the Home at the time but that no action seems to have been taken. CCOs, and even Mr Skinner, the Children's Officer, knew her approach to children to be harsh. We found no evidence of any supervision or disciplinary process and no recorded warnings in relation to her known conduct. Given the seriousness of her abuses and the many years over which they were perpetrated, we conclude that the tolerance of her practice, by her managers and by Children's Services, was inexcusable and an inadequate response, even taking into account the absence of policies and procedures for responding to allegations of mistreatment.

9.4 Henry Fleming lived close to HDLG and was interacting with residents of the Home. Concerns were raised about him in the mid-1970s. In August 1975, he admitted to the Police that he had engaged in sexual activity with children from the Home. He described how he had indecently assaulted children over a period of two or three years. He was convicted and sentenced to two years' imprisonment. We found that children had been visiting him for several months before any investigations as to his suitability to entertain children had been carried out. There was, at the very least, an awareness that children had been receiving alcohol and cigarettes from him. By early August 1975, his sexual assaults on children from HDLG were known about. However, this was only reported to the Connétable when initial attempts to discourage children from visiting had failed. We consider this response to have been inadequate and as a result those charged with the care of children failed in their duty to take adequate measures to protect those children from sexual abuse. Furthermore, we noted a memo that suggests that there was no plan to inform parents about what had happened to their children. We consider this to have been inadequate, and we are critical of the possible motivation: to protect reputations.

9.5 In 1988, two residents at Clos des Sables disclosed to CCOs that Les Hughes had sexually assaulted one of them. The girl said that she did not want anything said to either Mr or Mrs Hughes, who were the Houseparents at Clos des Sables. The Houseparents were not informed. We find that this response

was not adequate. The fact that the child did not want Mr and Mrs Hughes to find out does not, in our view, excuse the inaction that followed the disclosure. This was a significant failure by the Education Department. A number of disclosures of sexual abuse were made during the 1980s to a staff member at Clos des Sables, who took no action. Her failure may be partly explained by her not having received any guidance on what to do, but we do not consider that this absolves her. Her evidence was that she thought it was up to the girls to go to the Police or someone in Children's Services, and that it was not up to her to go on behalf of the children. We find that to be a completely unacceptable attitude, even for the standards of the time.

9.6 Anton Skinner was advised by a Crown Advocate that he should look into the failure of his staff member to take action, and to consider what action should be taken. The Crown Advocate also said to him that he would *"no doubt wish to give thought to establishing a fixed policy by virtue of which any complaint, no matter how apparently ill founded will be given formal attention"*. Mr Skinner failed to follow up on this advice; neither did he follow up on his stated intention to prepare an in-depth report into what had happened. We find this inexplicable and inexcusable. The Education Department's failure to take any action against the staff member was, in our opinion, another failure to acknowledge and tackle failures in responding to disclosure of abuse.

9.7 In the Report, we deal, at length and detail, with the situation at Blanche Pierre, where Jane and Alan Maguire perpetrated abuses against children in their care and recorded their actions in the Home Diaries. A prosecution against the Maguires was pursued but then abandoned in 1999, following which Dylan Southern, the Head of Mental Health Services, was commissioned to produce a report as to whether there was a disciplinary case against Jane Maguire.

9.8 We find that it was adequate and appropriate for the Health and Social Services Department to have carried out an investigation into Jane Maguire in 1999. We consider that Dylan Southern wrote a clear and measured report and we reject the criticisms levelled at him by Anton Skinner. Despite Mr Southern's identification of failings on the part of Children's Services, and in

particular Anton Skinner, no action was taken by the States' chief executive officer in response. In our opinion, Anton Skinner's conduct, which is detailed in the Report, should have been subject to formal investigation.

9.9 The Report contains considerable details of many cases of reported abuse. In respect of some we find adequate action was taken. We have, however, identified many failures by staff and managers to take appropriate and timely action that might have prevented further abuse. We found in some cases that there was an avoidance by staff at all levels of their responsibility to take robust steps in the interests of protecting the children in their care.

Response of the SOJP to concerns about abuse

10.1 Chapter 10 addresses the response by the States of Jersey Police to concerns of abuse. It considers the structure and development of the SOJP with particular reference to Operation Rectangle and to the action taken where abuse was suspected.

Organisation of child protection investigations in SOJP

10.2 The Report sets out the history of specialist child protection work in SOJP, from the early Child Protection Team to the current Public Protection Unit. Many officers, in their evidence to the Inquiry, recognised that the rarity of serious crime in Jersey meant that senior officers would often not have the experience that officers of similar rank in the UK would have.

10.3 We have described the appointment and approaches of officers from the UK – specifically, Graham Power, Lenny Harper, Michael Gradwell and Alison Fossey – and their roles, both in developing the established specialist child protection unit in Jersey and in the response to the allegations of abuse that emerged throughout Operation Rectangle. The key role of now-DCI Fossey in building the team and developing its professionalism and expertise is highlighted.

10.4 The Report addresses the struggles that the team faced to secure sufficient resources. We concur with now-DCI Fossey's view that "*Child protection presents the biggest threat and risk to any police force in the country. Jersey*

didn't recognise that, therefore the resources did not get prioritised to that". We accept that, at times, the child protection unit of SOJP was under-resourced and we accept Graham Power's evidence that nobody deliberately starved the team of funds. Rather, it was subject to constraints shared by other SOJP departments, though notably, and commendably, it was, in 2006, the only fully staffed unit in the force. DCI Fossey told us that when she joined the then Family Protection Team in 2005, she noted there were many child protection investigations but few prosecutions.

10.5 We considered the role of the Honorary Police in the prosecution of child protection cases. By the early 1990s, both the SOJP and Children's Services were expressing concern about the role of Centeniers in child abuse cases. One particular Centenier was thought to be unwilling to pursue such cases. Anton Skinner, then the Children's Officer, wrote to the Bailiff in 1991, expressing concern about the lack of protection of child witnesses in the Magistrate's Court, caused in his view by the fact that Centeniers, not professional prosecutors, presented the cases. Two years later in 1993 Marnie Baudains also highlighted a number of difficulties in the prosecution of child abuse cases arising from the fact that a Centenier, not a lawyer, was responsible at that time for prosecution up to and including the Magistrate's Court stage. We consider that these criticisms were well founded. We conclude that the role given to the Honorary Police and the attitudes of some Centeniers contributed to insufficiently robust approaches to the prosecution of child abuse cases and a consequential lack of confidence by victims and other professionals in the system.

10.6 We consider that changes in recent years, including the appointment of force legal officers requiring that prosecutions be undertaken by legally qualified personnel, have addressed the problems in the system. The Report also describes the role that the Honorary Police had up until the early 2000s in responding to cases of child abuse, child neglect and domestic violence, and the concerns that existed in the SOJP and Children's Services that an overly informal or lenient view was often taken of such serious offences by the Honorary Police. We commend the efforts and persistence of Marnie Baudains, Bridget Shaw, Alison Fossey and their colleagues in lobbying

successfully for these matters to become the exclusive responsibility of the SOJP. Given the dual role of the Attorney General in heading the island's prosecution service and heading the Honorary Police, these matters could, and should, have been addressed much earlier in Jersey's history.

10.7 The report examines, in considerable detail, the SOJP response to specific allegations of abuse made by children in the care system. We note that attitudes to such allegations started to change in the mid-1990s, when Barry Faudemar took over as DS of the child protection team, and the damage that abuse could do and had done to children in the system was better recognised. Some evidence from the early 2000s, however, indicates that allegations of assault made against staff by young people at Les Chênes were sometimes viewed as a consequence of *"reasonable force"* being needed on occasion to managed "*difficult"* young people, We conclude that, in respect of allegations by WN360 and others, the investigating officer was too heavily influenced by his negative perceptions of Les Chênes residents. In this case we also conclude that the officer used the wrong test to determine whether to send the case for consideration of prosecution. We note, however, that the advice not to prosecute in the case of WN360 was strongly challenged by DI Robert Bonney. The Report covers many cases investigated during Operation Rectangle (2007–2010) and concludes that these investigations were all appropriately managed by the SOJP.

<u>Working relationship between SOJP and Children's Services</u>

10.8 In considering the working relationship between the SOJP and Children's Services, we note different attitudes among different child care teams. While Children's Services child protection staff and emergency duty child care officers had a positive and constructive working relationship with the SOJP, police officers found the Long-Term Team, particularly under the leadership of Danny Wherry, to be obstructive in many respects. They considered that the Long-Term Team put too much emphasis on keeping families together rather than protecting children. DCI Fossey said that the team were slow to report suspected offences against children. We concur that the preservation of working relationships with families should only ever be a secondary

consideration when a child is believed to have endured, or be at risk of, harm. We consider these criticisms of the Long-Term team to be well founded. The fact that other teams in the service were working to appropriate professional standards of child protection practice suggests that there was a failure of management to address problems of performance standards and to ensure consistency across the department.

10.9 We concur with the view of SOJP that the failure of Anton Skinner to report to the Police in 1990 allegations of abuse by Jane and Alan Maguire was inexcusable.

SOJP investigations into Victoria College, Paul Every and Sea Cadets

10.10 The SOJP investigations into Victoria College, Paul Every and the Sea Cadets are not within the Inquiry's Terms of Reference. Nevertheless, we considered evidence about these investigations, on the basis that the conduct and attitude of Police officers and others might be relevant to the Police response to allegations of abuse of children in care. Further, these investigations all preceded and formed part of the background to the SOJP's major investigation into historic child abuse: Operation Rectangle. We set out the detail of these investigations in the Report.

10.11 In respect of the Victoria College investigations, we concur with the conclusions of the 1999 investigation report, completed by Steven Sharp, that if the correct procedures had been followed by the school, it is most likely that Mr Jervis-Dykes would have been suspended and perhaps arrested seven years earlier, in 1992. We set out in the Report why we conclude that there was no evidence that there were deliberate attempts to impede these investigations. We note that former Chief Officer Graham Power concluded that there was no basis for a criminal investigation into any cover-up in relation to past decisions.

The origins of Operation Rectangle

10.12 The SOJP were aware, by mid-2007, of a number of apparently unconnected offences or alleged offences against children, said to involve people in influential positions who had easy access to children. There was evidence of

past as well as more recent abuse. In those circumstances, the instigation of an operation to look for any links between these offences and/or to determine whether there were other offenders who had preyed on vulnerable children was clearly justified.

10.13 The Report covers the events leading to the establishment of Operation Rectangle. We have examined the suggestion that, early on, attempts were made by senior officers to dismiss the proposal by DI Hewlett and DC Carter that an investigation was required into historic instances of abuse in the island's care homes.

10.14 We set out the reasons why we have found that there was an inadequate and insufficiently urgent response by senior officers to the matters raised by DI Hewlett and DC Carter. We are not convinced, however, that any actions were taken deliberately to obstruct the investigation of abuse.

Operation Rectangle – political involvement

10.15 In relation to Operation Rectangle, we have described the investigation from its covert stage in 2007 through to its conclusion in 2010, and we discuss its leadership at each stage.

10.16 In terms of political involvement in Operation Rectangle, we accept Mr Power's view that, initially, politicians did not grasp the urgency and importance of the investigation or the need to prepare for media and public interest and scrutiny. We concluded also that the initial lethargic political response was due to this failure rather than any attempt to impede the investigation. We set out in the Report, in detail, the events surrounding the public announcement of Operation Rectangle, which was precipitated by former Senator Syvret's invitation to the BBC to make a programme about historical abuse in Jersey. We note Mr Harper's evidence that Bill Ogley, Chief Executive, and Chief Minister Frank Walker did not want an investigation and that they had told him that it would bring down Jersey's government. Mr Walker refuted this and said that, while he and Mr Ogley were unhappy about the fact that an investigation was needed, that did not mean that they were opposed to one taking place. Mr Ogley said that the view of the Chief Minister

was that nothing should stand in the way of bringing perpetrators of abuse to justice.

10.17 The Attorney General, William Bailhache QC, recommended to Mr Power that suggestions of political cover-up would best be dealt with by asking an external force to conduct the investigation of allegations of abuse. Mr Power was clear that the Attorney General was not seeking to discourage an investigation but was asking for it to be demonstrably independent. Mr Power took extensive advice, including from outside the island, on the original prosecution decisions in relation to the Victoria College, Paul Every, Jane and Alan Maguire and other earlier cases. He concluded that there was no basis for a criminal investigation into any cover-up in these cases, based on the available files. There was no review of whether the Police investigation in these cases was in any way flawed. We accept that both the Attorney General and Graham Power acted in good faith in their approach to the allegations of past cover-up. We believe that Graham Power acted appropriately in seeking independent legal opinion.

10.18 We note that, following the publication of a Serious Case Review about which Senator Syvret raised concerns, an independent review of child care by Andrew Williamson from the UK was launched. The Council of Ministers also decided that a public inquiry would be held in due course.

10.19 We have briefly recounted in the Report the events following on from Senator Syvret's scathing public criticisms of the performance of his own department, of which he had been Minister for eight years, to his dismissal as a Minister. We find that Stuart Syvret highlighted relevant issues about child abuse that needed to be addressed to ensure the protection and safety of children in Jersey. His actions did not amount to political interference with Operation Rectangle.

10.20 We agree that Mr Syvret’s public criticisms of civil servants were inappropriate and did not assist his cause. We accept that Frank Walker and Bill Ogley were genuinely troubled by his conduct in this respect, and we do not believe that the attempts to remove him were conducted with the intention of covering up child abuse. In those circumstances, further consideration of the reasons

for, and manner of, his removal from post does not fall within our Terms of Reference.

10.21 The Inquiry is not required to determine whether policing decisions were right or wrong, except in so far as those decisions have a direct relevance to the Terms of Reference, specifically the response of the SOJP to the abuse allegations and the process by which files were submitted to prosecuting authorities and the way in which decisions to prosecute were made.

10.22 A great deal of media attention was generated by the SOJP press statement dated 24 February 2008, which included the assertion that *"the partial remains of what is believed to have been a child"* had been found at HDLG. Subsequent scientific analysis revealed that the item, believed at that time to be part of a child's skull, was not human bone and was probably coconut shell. Graham Power agreed that making the assertion quoted above in the press statement was *"not good".* Mr Power explained that Mr Harper believed that the fragment found was part of a skull because of the preliminary view of the forensic scientist on site. He accepted that more should have been done to correct inaccurate press reporting. The Inquiry has also seen correspondence and notes of meetings involving politicians, the Attorney General, Graham Power and Lenny Harper, in which the Attorney General urged politicians not to intervene. He also sought to persuade the SOJP to correct inaccurate reporting.

10.23 The Attorney General stated repeatedly his concern about the effect of publicity on any prosecutions. Senator Ben Shenton was highly critical of the handling of the media interest in the investigation, and he expressed this strongly in a letter to Senator Wendy Kinnard, who was Minister with responsibility for policing. Mr Power, who saw the communication, saw this criticism of Ms Kinnard's oversight as political interference in the HDLG investigation. We do not accept that this was the case. On 3 March 2008, Mr Walker, while acknowledging that questions might need to be asked about the conduct of the media-handling aspects of the investigation, tried to calm matters by urging all Ministers to desist from comment and questions about the investigation until it was concluded.

10.24 On 27 March 2008, the Council of Ministers announced that a public inquiry would take place at the conclusion of any criminal proceedings. Four days later, Mr Walker and his wife were given a tour of the crime scene by Mr Harper, who told them that new forensic evidence indicated that no murders had taken place. No public announcement was made to this effect. In May 2008, further specimens, including children's milk teeth and bone fragments, underwent forensic testing. Subsequently, no findings emerged that warranted the launch of a homicide investigation.

10.25 It became public knowledge that the Director of Education at the time, Mario Lundy, was suspected of the physical abuse of children. Graham Power said that, at a meeting attended by himself, Bill Ogley and Mario Lundy, Mr Ogley said: *"If anyone wants to get Mario they will have to get me first."* Graham Power said that the statement was met with applause by some of those present and he took this incident as indicating the closing of ranks by the *"in crowd"* against the *"threat"* of Operation Rectangle. His view was that politicians and those in government were willing to cover up child abuse in order to protect Jersey's reputation.

10.26 Former Minister Wendy Kinnard told the Inquiry that she did not believe that Ministers wanted to cover up abuse; they just wanted the issue to go away, and one way of achieving that was "*to minimise it*". The public perception at that time was, we believe, succinctly dealt with in the submissions to this Inquiry by the JCLA:

> *"It would be wrong and misleading to suggest that any of the politicians condoned child abuse, but the stance they adopted led to a rapid polarisation between those who wanted aggressively to pursue the investigation and those who had concerns for Jersey's reputation. Some politicians wanted to have it both ways which only seemed to compound the problem which was being created, that is, a breakdown in trust."*

10.27 On 9 May 2008, Jersey's Bailiff, Sir Philip Bailhache, made the Liberation Day speech, which included the statement:

> *"All child abuse, wherever it happens, is scandalous, but it is the unjustified and remorseless denigration of Jersey and her people that is the real scandal."*

10.28 We have considered whether Sir Philip's words indicated a belief on his part that the reputation of Jersey was of more importance than the child abuse investigation. We cannot accept that a politician and lawyer of his experience would inadvertently have made what he told the Inquiry was an *"unfortunate juxtaposition"* of words. We are sure that the way in which Jersey is perceived internationally matters greatly to him. His linking of Jersey's reputation to the child abuse investigation was, we are satisfied, a grave political error, rather than a considered attempt to influence the course of the police investigation.

10.29 We find that there was disquiet among Jersey's politicians, up to and including the Chief Minister, Frank Walker, about the effect on the island of the publicity being generated by Operation Rectangle. Nevertheless, we find that Frank Walker and the majority of politicians accepted the strong advice of the Attorney General and did not seek actively to interfere. We find that Ministers in general recognised that, however unpalatable the outcome of Operation Rectangle might prove to be, the Police investigation had to be permitted to run its course unhindered. The alternative, leading to public accusations of cover-up, would have been far worse for Jersey's reputation, and we find that politicians recognised that fact.

10.30 Nevertheless, we accept that CO Graham Power would have felt under pressure from questions raised with him about Police handling of media and publicity, and also the conduct of DCO Lenny Harper. The questions raised by Frank Walker, Bill Ogley and others undoubtedly reflected genuine concerns but caused Mr Power to believe that he did not enjoy the political support that was being asserted in public.

<u>Operation Rectangle – SOJP relationship with LOD</u>

10.31 The Report considers the difficulties in the relationship between the SOJP and the LOD during the course of Operation Rectangle insofar as they impacted on the investigation and prosecution of cases of the abuse of children in care. As Mr Power told the Inquiry, perception issues arose from the fact that Jersey does not have an equivalent to England and Wales' independent Crown Prosecution Service. In Operation Rectangle, decisions as to the prosecution of government staff lay in the hands, he said, of those perceived

to be the *"government's lawyers".* This, he said, undermined the confidence of some victims, witnesses and even police officers. In his view, even the robust safeguards put in place by the Attorney General for decisions about Operation Rectangle cases were insufficient to dispel the perception of conflict of interest and promote faith in the system, even if the decisions made were correct. We consider the offer by the Attorney General to SOJP of an independent lawyer with experience in cases of abuse to have been a helpful, neutral initiative. We recognise, however, the frustration of the SOJP that the lawyer was not working full time on Operation Rectangle, and that this added to tensions between the SOJP and the Law Officers' Department.

10.32 We have concluded that the relationship between the Operation Rectangle Police team and the Law Officers was poor almost from the outset, largely because of the lack of trust on the part of the Police in the ability of the Law Officers to make decisions that would be perceived by the public as fair and independent. Relations worsened substantially from February 2008, with the increasingly hysterical and inaccurate media reporting of the progress of the Police investigation. A crisis in the relationship occurred in July 2008, with the issuing by Lenny Harper of a press release, criticising the decision not to prosecute WN279 and WN281.

10.33 The mutual distrust in the working relationship undoubtedly caused problems in an investigation that was difficult in any event. The Police were investigating allegations of abuse, which in some cases were alleged to have occurred many years in the past. Evidence of such abuse is, by very reason of the passage of time, often extremely difficult to obtain. Once evidence is obtained, prosecutors have to exercise fine judgement in order to determine whether prosecution is justified. A fractious working relationship between Police and lawyers could only have made the tasks for each side more fraught with difficulty. We have concluded, however, that the essential policing work and the process of giving legal advice and making prosecuting decisions were not significantly affected by the disputes. The Operation Rectangle Police team was staffed by experienced officers, with now-DCI Fossey having a leading role as Deputy SIO. We have seen no evidence to indicate that the

evidence-gathering role of the Police was hindered to any material extent by the poor relationship between lawyers and the Police.

10.34 The arrival from the UK of experienced senior officers David Warcup and Michael Gradwell, following Mr Harper's retirement, clearly improved the working atmosphere, but we have no reason to believe that the integrity of the work of either Police or lawyers was affected by the change in Police leadership of Operation Rectangle. We commend the thoroughness with which now-DCI Fossey and her colleagues pursued investigations, including their efforts to track down former Jersey care home residents to ensure that all were accounted for.

Suspension of Graham Power

10.35 In November 2008, Graham Power was suspended by the then Home Affairs Minister, Andrew Lewis. The reasons given related to alleged failings in the management of Operation Rectangle. Operational policing decisions are not a matter for this Inquiry, save to the extent that they had an effect on the Police response to allegations of the abuse of children in care.

10.36 We have set out in the Report the detailed sequence of events leading to Mr Power's suspension, including the concerns of the LOD that inaccurate reporting of aspects of Operation Rectangle, if uncorrected, could jeopardise the first prosecutions arising from the investigation that were about to take place. We have also considered the report by Dr Brian Napier QC, an expert in employment law, who subsequently investigated Graham Power’s suspension in the light of all the additional evidence that we have received and the different account of events given to us by former Minister Andrew Lewis.

10.37 We record our disquiet at the manner in which the suspension of Mr Power was handled and in respect of some of the evidence given to us about it. We note the fact that Graham Power was suspended with no notice in respect of alleged past failings, when there was no suggestion that those past failings could have an effect on his ability in future to carry out his duties.

10.38 Those responsible for Mr Power's suspension did not heed the advice of the Solicitor General or the Attorney General about the risks of reliance on an interim report by the Metropolitan Police Service into the management of Operation Rectangle, and the need to show to Graham Power any report on which they were relying and permit him to comment on it. They also did not accept the wisdom of awaiting the full Metropolitan Police Service report before taking action. We find that David Warcup exaggerated to Bill Ogley the extent to which his own concerns were supported by the Metropolitan Police Service interim report. We also find that Andrew Lewis used the interim report for disciplinary purposes, knowing that this was an impermissible use.

10.39 We accept the evidence of the then Attorney General, William Bailhache QC, who understood that the decision to suspend Graham Power had already been made by the evening of 11 November 2008, in advance of the meeting with Mr Ogley and Andrew Lewis the following day. His evidence to us on this point was at odds with the evidence of Bill Ogley. We prefer the evidence of Mr Bailhache. It is clear to us that when Graham Power attended the meeting on 12 November 2008, his suspension was inevitable. We accept Graham Power's evidence that he was given time *"to consider his position"* – in other words, to resign as an alternative to suspension;

10.40 We find that Andrew Lewis lied to the States Assembly about the Metropolitan Police Service report, stating that he had had sight of it when he had not. We can readily see why these acts have given rise to public suspicion that all or some of those involved were acting improperly and that they were motivated by a wish to discredit or close down investigations into child abuse.

10.41 We recognise that there were, at the time of Graham Power's suspension, genuine reasons for concern about some aspects of the past conduct of Operation Rectangle, in particular, the media handling, and that there may well have been reasons to investigate whether (a) there were failings in the conduct of the operation; and (b) if there were, the extent to which Graham Power was responsible for them.

10.42 We cannot be sure why Frank Walker, Bill Ogley and Andrew Lewis acted as they did, or why Andrew Lewis lied both to the States and to us. Frank Walker

described Andrew Lewis as an inexperienced politician, and even appointed a more senior politician to mentor him in his Home Affairs role. While Frank Walker told us that, nevertheless, he did not think that Andrew Lewis would have been influenced by his view as Chief Minister, we believe not only that such influence was inevitable but also that it would have been recognised by all involved, including Frank Walker and Bill Ogley. Whatever the motivation, however, nothing that we have seen suggests that the suspension of Graham Power was motivated by any wish to interfere with Operation Rectangle or to cover up abuse.

10.43 It was clear that Operation Rectangle was going to continue with or without Graham Power's presence; he had never, in any event, had a significant operational role in the investigation and, following the arrival of David Warcup, had been content to leave the running of the investigation to David Warcup and Michael Gradwell. Neither of them came from Jersey, and we have no reason to believe that they would have taken the opportunity of Graham Power's suspension to close down the investigation or to take any other steps that they would not have taken had he remained in post. We commend the SOJP for ensuring that Operation Rectangle did not conclude until then-DI Alison Fossey and her colleagues were confident that they had accounted for every child who had been resident at HDLG.

Prosecution decisions

11.1 Chapter 11 deals with decisions on prosecutions, as required by Term of Reference 13, which asks us to consider:

- whether those responsible for deciding on which cases to prosecute took a professional approach; and
- whether the process was free from political or other interference at any level.

11.2 To assist us in this task, we instructed independent leading counsel in London, Nicholas Griffin QC, to examine eight sample prosecution files and to give an opinion on the approach to and decisions made in each case by those involved in case preparation and decision making.

11.3 It does not matter whether Mr Griffin QC would have come to the same prosecuting decisions. We recognise that two competent individuals exercising professional judgement may reasonably reach different views. What he was reviewing was the professional competence of those involved in the decision-making process.

11.4 The decisions reviewed were mainly, but not all, made in the course of Operation Rectangle. They were a representative sample of the working practice of the prosecuting authority. Mr Griffin QC concluded that the decisions were appropriately and properly taken. It was then for the Inquiry to reach its own conclusion, taking this opinion into account.

11.5 In Jersey, the head of the prosecution service is the Attorney General, who is also the principal legal adviser to the States of Jersey. While this is comparable with arrangements elsewhere, it has been the subject of some criticism in Jersey. The role was, however, reviewed by Lord Carswell in 2010, and he concluded that the current arrangement should continue. We heard from John Edmonds, Director of the Criminal Division in the Law Officers' Department, who assured us that, during Operation Rectangle, he never felt uncomfortable professionally with what was being done and the decisions that were taken.

11.6 Prosecution decisions in Jersey are made in accordance with the same two-stage test as is applied in England and Wales. Stage one requires an objective assessment of the evidence, addressing the following question: is a prosecution more likely than not? If that test is passed, then a subjective test of the public interest is applied. We heard in some detail from former Attorneys General as to how they had applied these tests and reached their decisions. While Nicholas Griffin QC pointed to some cases where he felt there may have been a conflation or inappropriate application of the public interest test, he considered that the test had been appropriately applied in other cases, some of which he said were *"very difficult from a lawyer's point of view".*

11.7 In Jersey, charging decisions are usually taken by Centeniers, who do not have any legal training. In Operation Rectangle, charges were brought by

Centeniers only after cases had been scrutinised by lawyers. We found no evidence of any Centenier, without the input of lawyers, refusing to charge an alleged perpetrator of child abuse.

11.8 We set out detail of the procedures regarding prosecution that were put in place for Operation Rectangle. We found that the approach of the SOJP remained essentially the same throughout the operation; the Police wished to prosecute alleged offenders where there was evidence to justify prosecution. There was, in our view, no improper attempt, following the arrival of Mr Warcup and Mr Gradwell into the SOJP, improperly to close or reduce the scope of the investigation. We have no doubt that, throughout the length of the operation, all policing and prosecuting decisions were made conscientiously and properly. We set out, in some detail, the cases that Nicholas Griffin QC reviewed and the opinions that he offered. These include some of the cases that have caused most concern, such as the prosecution of Alan and Jane Maguire. We also detail a number of other cases that were not reviewed by Nicholas Griffin QC, but about which we received evidence. We set out, for each case, the view we reached as to the decision-making process. In each of these cases we found that the decision-making process was carried out professionally and appropriately.

11.9 We gave consideration to the law on corroboration that applied in Jersey. This required there to be corroboration of the evidence of a child under 14 before a defendant could be convicted on that evidence. In 1991, Anton Skinner, the Children's Officer, wrote to the Bailiff, requesting an urgent review of this law because *of "an inability to progress legally towards criminal prosecution in an increasing number of cases where there has been no doubt in the minds of investigating officers that grave offences against children have occurred"*. He went on to say: *"regrettably the law as it currently stands does not appear to be able to protect the interests of children in the matter of child abuse and most particularly sexual abuse"*. It took until 1997 before the law was changed so that there was no longer a bar to prosecution in which the evidence of a child was uncorroborated. A judge was, however, still required to give a warning to the jury of the dangers of relying on the uncorroborated evidence of children or complainants of sexual abuse.

11.10 In 2009, John Edmonds wrote to the Attorney General, saying:

"the Legal Advisers over a period of many years have effectively been applying a test of mandatory corroboration rather than properly evaluating whether an uncorroborated victim would nonetheless be regarded as a witness of truth". He went on to say: "*I fear that Ian Christmas' involvement both as a Legal Adviser and Magistrate set the tone for much of this practice."* The Inquiry tried to contact Mr Christmas, but without success. Nonetheless, John Edmonds said, in respect of Operation Rectangle decisions: *"there isn't a single case where in my assessment the fact that there was going to be a mandatory corroboration warning tipped the balance between prosecuting and not prosecuting".*

11.11 In 2008, the Council of Ministers considered a change in the law of corroboration, decided further advice was needed and referred the issue to the Law Commission, which reported in 2009. It was not until 2012 that the law was eventually changed.

11.12 We conclude that the failure to amend the law on corroboration, coupled with the failings of Ian Christmas and others in the application of the existing law, did contribute to decisions not to prosecute before Operation Rectangle. We accept that the law was correctly applied during Operation Rectangle and that the fact that there was going to be a mandatory corroboration warning did not tip the balance.

11.13 We conclude that the failure to act to change the law on a matter vital to securing justice for children and victims of sexual offences reflected the lack of importance accorded to this issue by the States, rather than incompetence.

From findings to recommendations

12.1 Chapter 12 addresses Terms of Reference 14 and 15, which require us to: *"Set out what lessons can be learned for the current system of residential and foster care services in Jersey and for third party providers of services for children and young people in the Island"* and to *"Report on any other issues".*

12.2 Our recommendations seek to address ten fundamental failings and eight key lessons to be learned that we have identified, in order to keep children in Jersey safe and to give children in the care of the States of Jersey the best life chances. In formulating our recommendations, we have also considered how Jersey has responded to previous child care reports and recommendations and have drawn on research on delivering successful outcomes from recommendations.

Ten fundamental failings in Jersey's care system

12.3 We consider that the ten fundamental failings in the Jersey child care system are:

(i) **Failure to value children in the care system, listen to them, ensure they are nurtured and give them adequate opportunities to flourish in childhood and beyond.** This includes lack of investment in the recruitment, management, supervision and continuing development of staff with suitable backgrounds and skills to care for children.

(ii) **Failure to have in place an adequate legislative framework that prioritises the welfare of children in need or at risk.** While the States of Jersey has always been able to provide sufficient resources to keep pace with developments in international financial law, Jersey's child care legislation has lagged behind other jurisdictions in the developed world – often by decades.

(iii) **Failure to keep pace with developments in social policy, child care practice and social work standards in the developed world.** For example, in Jersey there has been an ill-considered, misguided and potentially harmful approach to secure accommodation that was used routinely for children whose needs would have not have met the threshold for secure detention elsewhere and without the thorough assessment or rigorous safeguards that were in place in other jurisdictions.

(iv) **Failure to plan and deliver services in an effective, targeted manner to achieve positive, measurable outcomes for children.** For decades, there was little evidence of a considered approach to the needs of and desired outcomes for individual children. At a strategic level, there was a marked

absence of government initiatives to tackle the causes of social inequalities and deprivation or to promote the welfare of children. In the youth justice system, punitive approaches were taken to children whose misdemeanours likely would not have reached the threshold for prosecution in other jurisdictions.

(v) **Failure to establish a culture of openness and transparency, leading to a perception, at least, of collusion and cover-up.** Jersey's culture has not encouraged the reporting of poor and abusive practice. At times, efforts to protect the island's reputation and international standing have led to insufficient acknowledgement of the gravity of the Island's failings and the egregious nature of some of the abuses perpetrated on children in its care. Such attitudes have fostered the suspicion, within parts of the community, that most politicians and States employees cannot be trusted and that abusive practices have been covered up.

(vi) **Failure to mitigate negative effects of small island culture and its challenges**. Failures have included ignoring or failing to manage conflicts of interest and prioritising the welfare of staff over the needs of children. Social connections have meant that, at times, there has been insufficiently robust professional challenge to poor practices.

(vii) **Failure to make sufficient investment in staff development and training.** Dedicated staff have not been truly valued, while unskilled staff have been allowed to run institutions or care for children with severe and enduring emotional needs.

(viii) **Failure to adopt policies which would promote the recruitment and retention of staff with essential skills in child welfare and child protection.** Incentives and expedited residency qualifications are available from the States to draw highly valued individuals and financial organisations to the island. In contrast, little effort has gone into creating the incentives that would make Jersey competitive in recruiting and retaining exceptional managers and staff to care for Jersey's children, who could be seen as the island's most valuable asset.

(ix) **Failure of the States of Jersey to understand and fulfil corporate parenting responsibilities, including adequate aftercare of children who have been looked after by the state.** The overwhelming majority of adults who have been in the care system, and whose stories the Inquiry heard, still suffer from the effects of abusive or emotionally neglectful childhoods in the care system, their difficulties often compounded by being turned out, unsupported, into a world with which they were singularly ill equipped to cope.

(x) **Failure to tackle a silo mentality among public-sector agencies.** States departments and institutions have been characterised by territorialism and protectiveness rather than openness to pooling resources and learning. As a result, there has been a lack of a comprehensive strategy to secure the bests interests of children in the island.

<u>The current state of care for children in Jersey</u>

12.4 Unfortunately, these are not only historic failings. In relation to current services for children, foster carers told us in 2016: *"The service is failing our children, leaves them very vulnerable and has not learned any lessons whatsoever no matter how many SCRs have occurred."* Interim managers arriving in 2014 found a management style within the residential sector, which was "*not conducive to keeping children safe*". They found children at risk in the community because care orders were being used inappropriately or not at all. Young people currently in the care system told us that they feel that they have no effective mechanism for making representations or raising concerns. They told us that they are not being listened to. We learned that staff in residential care settings still relied on outdated containment and behaviour management methods of care rather than approaches geared to creating the therapeutic environments and relationships to enable children to recover from adverse experiences.

12.5 We heard that lessons of the past have not been learned over long periods because of a "*moribund*" senior management that had come about because of "*too many internal promotions over too long a period*". In its submissions to the Inquiry, the States of Jersey acknowledged that there had been a reluctance by staff in child care services to engage in robust professional

challenge and supervision because of existing social relationships. It is a matter of grave concern that such attitudes persist over a quarter of a century after the problems of Blanche Pierre first came to light.

12.6 There was a strong contrast between the positive accounts by some recent managers of improvements and achievements in Children's Services and other evidence we heard. We do not believe that the Inquiry was intentionally misled: we believe that the discrepancy between how some staff perceive the quality of service and how it actually functions is a reflection of their "*not knowing what good looks like"* in modern child care practice.

12.7 Service quality has also been affected by Jersey's inability to recruit and retain sufficient numbers of high-calibre child care professionals.

12.8 For all those reasons, we believe that, as late as the end of the Inquiry's hearings, aspects of Jersey's services for children remained not fully fit for purpose. In the light of all the evidence that it has heard, the Panel considers that children may still be still at risk in Jersey and that children in the care system are not always receiving the kind or quality of care and support that they need.

Hope for the future

12.9 The current picture is not entirely bleak. The Panel encountered enormous resources of goodwill and generosity in the island, and many people with a passionate commitment to the island's children who were developing resources and supporting and advocating for young people and disadvantaged groups. We were impressed by staff and volunteers in many agencies, by innovative models of care in the voluntary sector and new approaches to interagency working. We heard from Ministers that States members should want no less for the children for whom they are "corporate parent" than they would for their own children.

Lessons to be learned

12.10 We found recognition, in all sectors and among all professionals, of the eight basic lessons to be learned from the failures of the past:

(i) **The welfare and interests of children are paramount and trump all other considerations.** Traditional values, operating and management practices, the needs or employment status of staff, convenience, HR practices and the reputation of the island should all be secondary considerations to the interests and welfare of children.

(ii) **Give children a voice – and then listen to it.** All children are different, and the "listen to children" box cannot be ticked by providing one process or one set of documentation.

(iii) **Be clear about what services are trying to do and the standards which they should attain.** Jersey needs to articulate its aspirations and the standards it seeks for the performance of staff, for children in its care and wider services for children in the island. It needs to have clear thresholds for state intervention in families, including in respect of youth offending.

(iv) **Independent scrutiny is essential.** Regular scrutiny of child care law, policy and practice by individuals or agencies entirely independent of Jersey is essential. While in Jersey, persons involved in such work should avoid even the perception of conflict of interest or partiality.

(v) **Stay connected**. Jersey must ensure that child care and youth justice legislation, policy and practice are not only compliant with current standards in the developed world, and with ECHR and with UNCRC principles, but also that legislation policy and practice are regularly being informed and evolving in line with research and developments.

(vi) **Investment is essential.** Every child in Jersey is key to securing the island's future, prosperity and international standing, but that will not be achieved without according the island's children's services priority comparable to its financial services.

(vii) **Quality of leadership and professionalism are fundamental requirements.** Services for the most vulnerable children should not be delivered simply by whoever happens to be available.

(viii) **Openness and transparency must characterise the culture of public**

services. Politicians and professionals should admit problems, shortcomings and failures and promptly address them. The establishment of this Inquiry and the freedom with which it has been allowed to operate has demonstrated a political will and public desire in the island to open Jersey's institutions to thorough, independent and robust scrutiny in order to secure the best interests of children.

Recommendations

13.1 Many recommendations made over the years in previous reviews have focused predominantly on developing processes, structures and procedures instead of identifying and setting out a roadmap for pursuing desirable outcomes and for transforming service users' experience. We have sought to avoid this and have also set out in the Report some features that we believe should be part of an approach by the States of Jersey to these recommendations. The key changes required are not procedural but cultural. The States of Jersey must commit to and invest urgently and vigorously in a new approach to overseeing, supporting, developing, delivering and scrutinising its services for children.

13.2 The "Jersey Way" should be one of intolerance of poor performance, having high aspirations for every child in the island, commitment to securing the best-quality services to enable disadvantaged children to have equal opportunity to fulfil their potential, and creating a culture where staff development is valued and promoted.

13.3 The experience of other inquiries and international research suggests that grounding recommendations in the realities, knowledge and experience of people in Jersey will improve the chances of successful implementation and successful outcomes. We also believe that they offer a strong opportunity for redeeming the heritage of Jersey's care institutions and transforming it into a legacy of safe, nurturing care for future generations of Jersey's children.

13.4 We have also taken the view that, rather than specify in detail how recommendations should be implemented, it is better to place the responsibility for deciding what will work best for Jersey's children in the

hands of those with strategic and operational responsibility. That having been said, we emphasise the crucial importance of openness and transparency in the considerations that follow if there is to be wide public confidence in the changes made. Engagement with the wider community must be part of putting in place an improvement plan.

RECOMMENDATION 1: A Commissioner for Children

13.5 We recommend that a Commissioner for Children be appointed to ensure independent oversight of the interests of children and young people in Jersey. Such a position should be enshrined in States legislation and should be consistent with what are known as the Paris Principles, as is the case with other Children's Commissioners across the UK and Ireland.

13.6 The independence of a Commissioner is essential if there is to be confidence in the post, and, to that end, we recommend that consideration should be given to any possibility of a joint appointment with other jurisdictions. We consider that this could only enhance the perception of independence. We consider this to be such an essential appointment that we make it clear that pursuit of potential joint arrangements should not delay the statutory establishment of a Commissioner for Children in Jersey.

RECOMMENDATION 2: Giving children and young people a voice

13.7 Alongside the appointment of a Commissioner, we consider that other steps are necessary to ensure that children in Jersey are given a voice. An effective complaints system is one key element in the structures that are necessary to ensure that looked after children are safe, and, to that end, we recommend that the current complaints system is replaced with one that is easily accessed and in which children and young people have confidence. The outcomes of complaints should be reported regularly to the relevant Minister, who, in turn, should present an annual report to the States.

13.8 This improved system should include the appointment of a Children's Rights Officer, who will have responsibility for ensuring that children in the care system, irrespective of where they are accommodated, are supported to ensure that their voice is heard and that the matters they raise are addressed.

This does not mean that every complaint is upheld, but that every complaint is given full and serious consideration and a proper and timeous response is made to the young person. Additionally, Jersey should develop a partnership with an independent, external children's advocacy service such as Become (formerly the Who Cares? Trust). This would, we believe, add a further element of independence and assurance. These measures should mean that there are people proactively monitoring the welfare of children in the care system as well as assisting children to voice concerns.

13.9 We also suggest that the Chief Minister should consider making a personal commitment to meet annually with care-experienced young people, to hear at first hand of their experiences, which is ~~a~~ process that we found profoundly moving and enlightening.

RECOMMENDATION 3: Inspection of services

13.10 A further essential element of keeping children safe is having an empowered, professional and truly independent inspectorate. Between 1981 and 2001, there were no independent inspections of services for children, and, since 2001, there have only been occasional ad hoc inspections. We believe that the current plans for an internal inspectorate are encouraging, but we also consider that an external element of scrutiny is required.

13.11 We recommend that Jersey establish a truly independent inspection arrangement for its children's services, which will have the confidence of children, staff and the wider public. We set out in our Report the elements essential to ensure the inspectorate is truly independent. We believe that it is vital that, within 12 months of publication of our Report, a statutory basis for inspection is established. We also set out proposals for including experienced lay persons and care-experienced young people in inspection teams.

RECOMMENDATION 4: Building a sustainable workforce

13.12 Recruiting and retaining suitably qualified staff at all levels is essential if services are to be improved and developed. We recommend that Children's Services be provided with a dedicated specialist HR resource to work alongside managers in building a stable and competent workforce. To achieve

this, there will be a need to consideration of wider matters, such as whether the current residency rules require variation in order to facilitate recruitment and retention of staff in this field.

13.13 We set out suggestions for breaking down silo working and developing a culture of corporate working across all public services in Jersey, led by senior politicians and the Chief Executive and his or her senior team. This includes using principles and practices that have seen the London Borough of Hackney in the UK transform their Children's Services and become employer of choice among professionals in this field, suitably adapted for the island context. We also propose mechanisms to address the very considerable dissatisfaction expressed from foster carers who play a key role in the care of vulnerable children.

RECOMMENDATION 5: Legislation

13.14 Legislation for children in Jersey has lagged behind the developed world. We have set out suggestions for Jersey keeping pace with other jurisdictions, including developing collaborations with English authorities. We heard from witnesses a view that the *Criminal Justice (Young Offenders) (Jersey) Law 2014* should have a section inserted into it recognising that the welfare of children should be a primary consideration. We agree with this proposal, but it is our view that this in itself would not be sufficient unless the whole system were amended to centre on the welfare of the child.

13.15 We recommend therefore that the youth justice system move to a model that always treats young offenders as children first and offenders second. It is also essential that those charged with dealing with children in a judicial capacity should have a sound understanding of the needs of young people and the issues that can impact on their lives. To that end, we recommend that a suitable training programme be put in place for the judiciary, including a requirement for refresher training to ensure that all carrying these onerous responsibilities are kept briefed on the latest thinking and research.

RECOMMENDATION 6: Corporate parent

13.16 The corporate parent is an important concept in social policy, and it is essential that all those with this responsibility have a common understanding and are equipped to fulfil those responsibilities. We recommend that, following every election, there should be mandatory briefing for all States members as to their responsibilities as corporate parents for looked after children, and that new States members would be unable to take their seat until this had been undertaken. To emphasise the importance of this responsibility we recommend that reference is made to this specific responsibility in the oath of office taken by members of the States Assembly. We firmly believe that the symbolism of this would be a powerful demonstration to move on from the failures of the past.

13.17 We set out how the responsibilities of the States to all of Jersey's children should be set out in a Children's Plan evidencing how they will enable all children for whom they have responsibility to achieve and fulfil their potential and support them into adult life. This plan should cover the same period as the Medium-Term Financial Plan and should be reviewed annually.

RECOMMENDATION 7: The "Jersey Way"

13.18 Throughout the course of our work we heard the term the "Jersey Way". While this was, on occasions, used with pride, to describe a strong culture of community and voluntary involvement, it was more often used to describe a perceived system whereby serious issues are swept under the carpet and people avoid being held to account for abuses that have been perpetrated. This was well summarised in the contribution of a Phase 3 witness who told us:

> "*We (also) have the impossible situation of the non-separation of powers between the judiciary and political and there is a lot of secrecy, non-transparency and a lack of openness. This brings with it the lack of trust, the fear factor that many have spoken about and contributes greatly to the Jersey Way."*

13.19 That fear factor and lack of trust must be addressed, therefore we recommend that open consideration involving the whole community be given to how this

negative perception of the “Jersey Way” can be countered on a lasting basis. While constitutional matters are outwith our Terms of Reference, we are of the opinion that this matter cannot be addressed without further consideration of the recommendations made in the Clothier and Carswell Reports.

RECOMMENDATION 8: Legacy issues

13.20 Finally, a number of legacy issues require to be considered.

13.21 Our proposals include that all of the Inquiry’s vast documentation is preserved in perpetuity, with all public documents being retained in the public domain. Consideration should be given to making that archive accessible and more easily searchable. Separate, secure and independent arrangements will be required for preserving material not in the public domain, to protect the privacy of those who have given evidence anonymously or in private. We have therefore set out our intention to deal with the arrangements for archiving after the publication of our Report, and we have made it clear that we will not transfer material until such time as we are satisfied that the arrangements will afford it proper protection.

13.22 We also recommend that there is some form of tangible public acknowledgement of those who have been ill served by the care system over many decades. This should allow experiences of those generations of Jersey children whose lives and suffering worsened because of failures in the care system to be respected and honoured in decades to come. The form of this acknowledgement will need to take into account the views of survivors, and the medium or approach adopted must recognise the realities of the past and speak to the future aspirations of the island’s looked after children.

13.23 We believe that the buildings at Haut de la Garenne are a reminder of an unhappy past or shameful history for many people. They are also a symbol of the turmoil and trauma of the early stages of Operation Rectangle, the attention it brought to the island and the distress it evoked in many former residents. We recommend that consideration be given as to how the buildings can be demolished and that any youth or outdoor activity or services for

children located on the site should be in modern buildings bearing no resemblance to what went before.

13.24 We recognised, from the outset of our work, how difficult it would be for many people to come forward to tell us of their experiences and for others to hear of those experiences. The availability of support has therefore been a priority for us throughout the Inquiry. The publication of the Report does not bring to an end the likely need for support, and we therefore recommend that arrangements for ongoing support are put in place for those who may feel that they need it.

Concluding remarks

13.25 Establishing the Independent Jersey Care Inquiry was a significant step for the States of Jersey to have taken on behalf of the people of the island. We have no doubt that there is a genuine commitment to learn from the past and to make improvements for the future. We are, however, aware that it is a common criticism of public inquiries across jurisdictions that there is, in the majority of cases, no follow-up to verify what action has been taken in respect of findings and recommendations that have been accepted by those commissioning the report. It is, of course, for the public bodies in Jersey to decide whether and how our recommendations are implemented. We do, however, consider that the recommendations in this Report form the basis of building a better and safer future for all children in Jersey.

13.26 It is our view that, from the outset, a mechanism should be established to monitor and verify the implementation of the recommendations. A transparent way of doing this, and one that we recommend, is that the Panel returns to the island in two years, to hear from those providing the services and those receiving them. We envisage that this would be undertaken in a public forum similar to Phase 3 of the Inquiry. It may be that the Children's Commissioner, when appointed, could invite the Panel, who would report within a very short timescale after hearing from key participants.

FROM FINDINGS TO RECOMMENDATIONS

EVIDENCE

Evidence from former residents, staff and others

FINDINGS

Findings on each Term of Reference

10 FUNDAMENTAL FAILINGS

- Failure to value children in the care system
- Failure to adopt an adequate legislative framework
- Failure to keep pace with advances in the developed world
- Failure to achieve positive, measurable outcomes for children
- Failure establish a culture of openness and transparency
- Failure to mitigate the negative effects of small island culture
- Failure to make sufficient investment in staff development
- Failure to promote the recruitment and retention of suitable staff
- Failure to fulfil corporate parenting responsibilities
- Failure to tackle a silo mentality

659 RECOMMENDATIONS

Recommendations from:
Phase 1 and 2 witnesses;
Phase 3 meetings,consultations and public sessions

11 CATEGORIES

- Advocacy, Listening and Responding
- Early Intervention and Prevention
- Experience of Being Looked-After/AfterCare
- Judiciary and Justice System
- Legislative Framework
- Political Priorities, Policies, Structures
- Safeguarding Children
- Services for Children
- Standards, Inspection and Scrutiny
- Transparency and Accountability
- Workforce Capacity and Development

8 LESSONS TO BE LEARNED

- Welfare of child trumps all other interests
- Give children a voice – and listen to it
- Have clear standards
- Independent scrutiny is essential
- Stay connected
- Investment is essential
- Quality of leadership must improve
- Openness and transparency essential

8 RECOMMENDATIONS

- Commissioner for Children
- Giving Children a Voice
- Inspection of Services
- Building a Sustainable Workforce
- Legislation
- Corporate Parent
- The Jersey Way
- Legacy Issues

Terms of Reference

The Committee of Inquiry ("the Committee") is asked to do the following –

1. Establish the type and nature of children's homes and fostering services in Jersey in the period under review, that is the post-war period, with a particular focus on the period after 1960. Consider (in general terms) why children were placed and maintained in these services.

2. Determine the organisation (including recruitment and supervision of staff), management, governance and culture of children's homes and any other establishments caring for children, run by the States and in other non-States run establishments providing for children where abuse has been alleged, in the period under review and consider whether these aspects of these establishments were adequate.

3. Examine the political and other oversight of children's homes and fostering services and other establishments run by the States with a particular focus on oversight by the various Education Committees between 1960 and 1995, by the various Health and Social Services Committees between 1996 and 2005, and by ministerial government from 2006 to the current day.

4. Examine the political and societal environment during the period under review and its effect on the oversight of children's homes, fostering services and other establishments run by the States, on the reporting or nonreporting of abuse within or outside such organisations, on the response to those reports of abuse by all agencies and by the public, on the eventual police and any other investigations, and on the eventual outcomes.

5. Establish a chronology of significant changes in childcare practice and policy during the period under review, with reference to Jersey and the UK in order to identify the social and professional norms under which the services in Jersey operated throughout the period under review.

6. Take into account the independent investigations and reports conducted in response to the concerns raised in 2007, and any relevant information that

has come to light during the development and progression of the Redress Scheme.

7. Consider the experiences of those witnesses who suffered abuse or believe that they suffered abuse, and hear from staff who work in the services, together with any other relevant witnesses. It will be for the Committee to determine, by balancing the interests of justice and the public interest against a presumption of openness, whether, and to what extent, all or any of the evidence given to it should be given in private. The Committee, in accordance with Standing Order 147(2), will have the power to conduct hearings in private if the Chairman and members consider this to be appropriate.

8. Identify how and by what means concerns about abuse were raised and how, and to whom, they were reported. Establish whether systems existed to allow children and others to raise concerns and safeguard their well-being, whether these systems were adequate, and any failings they had.

9. Review the actions of the agencies of the government, the justice system and politicians during the period under review, in particular when concerns came to light about child abuse and establish what, if any, lessons are to be learnt.

10. Consider how the Education and Health and Social Services Departments dealt with concerns about alleged abuse, what action they took, whether these actions were in line with the policies and procedures of the day, and whether those policies and procedures were adequate.

11. Establish whether, where abuse was suspected, it was reported to the appropriate bodies, including the States of Jersey Police; what action was taken by persons or entities including the police, and whether this was in line with policies and procedures of the day and whether those policies and procedures were adequate.

12. Determine whether the concerns in 2007 was sufficient to justify the States of Jersey Police setting in train “Operation Rectangle”.

13. Establish the process by which files were submitted by the States of Jersey Police to the prosecuting authorities for consideration, and establish –

i. Whether those responsible for deciding on which cases to prosecute took a professional approach;

ii. Whether the process was free from political or other interference at any level.

14. Set out what lessons can be learned for the current system a residential and foster care services in Jersey and for third-party providers of services for children and young people in the Island.

15. Report on any other issues arising during the Inquiry considered to be relevant to the past safety of children in residential or foster care and other establishments run by the States, and whether these issues affect the safety of children in the future.

The Report of the Independent Jersey Care Inquiry 2017

Chaired by Frances Oldham QC

Volume 2: Addressing the Terms of Reference

Presented to the States of Jersey

on 3 July 2017

by the

Independent Jersey Care Inquiry

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FOREWORD

Our remit has been to establish what went wrong in the island's care system over many decades. This we have done, mindful of the duty that any society has to the most vulnerable of its members.

That there were failings is not in dispute. The States of Jersey final submissions stated:

> *"It is, without doubt and of incalculable regret, that children have been failed whilst in the care of the States of Jersey."*[1]

It is clear to us, and dealt with in this Report, that efforts have been made, and are being made, to improve the care system in Jersey. As the States of Jersey acknowledged in its closing submissions to the Inquiry:

> *"It is, however, recognised that in the area of legislation and policy, there is still a significant amount of work required."*[2]

A looked after child is already at a disadvantage in his or her journey through life compared with a child being raised in a loving family. It does not matter whether the disadvantage results from a circumstance of birth or from events within the child's birth family. It does not matter whether the disadvantage is the result of a crime committed against the child or even a crime committed by the child. In order to overcome that disadvantage and have a fair chance of a productive and happy life, he or she needs more, not less, care and attention than a child who is not in care.

Treating children in care as a statistic or as a resource issue low on the list of financial priorities fails those children and shames the society that makes that judgement.

A care system in which insufficient effort is made to prevent children from being abused, whether physically, emotionally or sexually, or a justice system in which insufficient steps are taken to investigate and punish such abuse where it occurs, is indefensible.

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[1] States of Jersey closing submissions, paragraph 55

[2] WD009424, States of Jersey closing submissions, paragraph 46

CONDUCTING THE INQUIRY

I was appointed to chair the Inquiry in October 2013, following the withdrawal of Sally Bradley QC as a result of the ill health that was to lead to her untimely death.

In due course, I appointed two Panel members to assist me. Alyson Leslie has a background in social work: her work includes serious case reviews into child abuse. Professor Alexander Cameron is a former Director of Social Work in Scotland and a former Chairman of the Parole Board for Scotland. He also has expertise in residential child care and fostering services. Their extensive experience in social care generally, and child care in particular, were of great assistance to me throughout the Inquiry.

Because Jersey is a small society, and because of the high emotions generated by the subject matter of the Inquiry, it was necessary for us to keep to ourselves and not mix socially on the island. I am further indebted to them for their fellowship and company.

Counsel to the Inquiry have worked tirelessly in assimilating and presenting a vast body of evidence. I personally would like to thank Patrick Sadd, Harriet Jerram, Cathryn McGahey QC, Paul Livingston and Stephen Doherty.

We have been enormously assisted, both during the Inquiry and in the preparation of this Report, by oral and written submissions from all Interested Parties.

In particular, we would like to record our appreciation of the assistance provided by Jill Gracia of the Jersey Care Leavers' Association. She attended the Inquiry daily and provided invaluable liaison for us.

It is important that we recognise the assistance given to witnesses by Victim Support Northern Ireland. They provided counselling and support throughout the evidence of the numerous, and at times harrowing, accounts of survivors. The fact that they were, and are, unconnected with Jersey gives them a credibility that no island-based organisation could provide.

It is equally important to recognise that the needs of those survivors will not cease with the publication of this Report. Therapeutic support under the Historic Abuse Redress Scheme continues to be available and can be accessed by all survivors through their General Practitioners.

Unlike most public inquiries, we did not have a dedicated secretariat. That burden fell on Eversheds, Solicitors to the Inquiry, and on the Panel. At the outset, the States of Jersey nominated Mike Haden to be Secretary to the Inquiry. We very soon realised the potential for conflict, or at least the perception of conflict, if we had a States employee, who was also an Honorary Police Officer, working within the Inquiry. That is not to take away any of the credit that is due to him for all the work that he did from the States Greffe in the physical set-up and logistics of the Inquiry.

The decision not to take advantage of the offer of Mike Haden as Secretary to the Inquiry was in keeping with our need not only to be independent, but to make it clear to all that we were not beholden to anyone.

We recognise the contribution of the Historic Abuse Redress Scheme, which was launched on 29 March 2012, once all criminal proceedings had been concluded. Some witnesses who gave evidence before us had had the benefit of counselling through the Redress Scheme. That gave them the courage to come forward and give evidence to us.

INTRODUCTION

I.1 On 6 December 2010, Jersey's Chief Minister made a formal apology to all those who had suffered abuse in the States' residential care system, acknowledging that the care system had failed some children in a serious way.

I.2 On 6 March 2013, the States Assembly formulated the Terms of Reference for what was to be a public inquiry undertaking a wide-ranging investigation into the abuse and mistreatment of children placed in children's homes and in foster care in Jersey from the Second World War to date.

I.3 On that occasion, the Chief Minister, Senator Ian Gorst, said this:

> *"It is the right thing to do for victims of abuse who want to recount their experiences to an independent inquiry. It is the right thing to do for our community so we can be assured that we have done everything possible to establish what went wrong and then to ensure it does not happen again."*

I.4 The 15 Terms of Reference set by the States of Jersey cover many different areas and have areas of overlap. Because of the overlap, each Term of Reference has not been dealt with separately in the Report. However, I am satisfied that each of the issues raised in the Terms of Reference has been addressed. The Report identifies, at the start of each chapter, those Terms of Reference covered in the chapter.

Overview

I.5 As I set out during the Inquiry's Preliminary Hearing on 3 April 2014:

> *"The Inquiry has been set up to establish what went wrong in the island's care system over many years and to find answers for people who suffered abuse as children."*

I.6 The Inquiry sat for 149 days of hearings and consultations, allowing over 200 witnesses to give evidence directly. Additionally, the evidence of over 450 former residents of, and those otherwise connected to, Jersey's care system was read into the record to enable the Inquiry to consider the broadest possible range of evidence. In order to provide a sufficiently substantial

evidential basis in addressing the Terms of Reference, the Inquiry processed and considered around 66,000 documents (a significant proportion of which amounted to many pages) and over 70,000 electronically stored documents (again, most of which ran to many pages).

I.7 The following Interested Parties took part in the hearings and made submissions:

- Jersey Care Leavers' Association;
- Law Officers' Department;
- Leonard Harper;
- Michael Gradwell;
- States of Jersey Police;
- The Government of Jersey, namely the Chief Minister's Department, Health and Social Services, Education, Sport and Culture, including the Probation and After Care Service and the Home Affairs Department.

I.8 I have incorporated, sometimes verbatim, some submissions in the Report, but only after a careful consideration of all submissions.

I.9 The Inquiry took the decision at the outset to divide its task into Phases of evidence as follows:

I.9.1 **Expert evidence:**

- Dr Philip Johnson, Associate Professor, Jersey Institute of Law;
- Tony Le Sueur, Policy Development, Governance and Quality Assurance Manager, States of Jersey;
- Professor Roger Bullock, Professor Emeritus of Child Welfare Research, Bristol University, and Fellow, Centre for Social Policy at Social Research Unit, Dartington; and Professor Roy Parker,[1] University of

[1] Now deceased

Bristol, and Fellow, Centre of Social Policy, Social Research Unit, Dartington. Professor Bullock attended the hearing to give evidence;[2]

- Richard Whitehead, Principal Legal Adviser, Law Officers' Department and Director of the Civil Division.

I.9.2 **Phase 1a** – evidence of and relating to former residents of children's homes[3] and foster care;

1.9.3 **Phase 1b** – evidence of those connected to the care system, including residential child care staff, managers of children's homes, Child Care Officers, the Children's Officer and senior management within the Education Department and the Health and Social Services Department. Phase 1b also heard evidence from those alleged to have abused children in care and those convicted of abuse of children in care;

I.9.4 **Phase 1bb** – evidence of those charged with political or other oversight of children's homes and fostering services during the relevant period;

I.9.5 **Phase 2** – evidence from the States of Jersey Police, the Honorary Police, politicians, civil servants and the Law Officers' Department;

I.9.6 **Phase 3a** – the Inquiry Panel's meetings with staff and volunteers from organisations who work with, advocate for or support work with children and service users;

I.9.7 **Phase 3b** – the consideration of expert evidence set out in paragraph I.9.1 above and from meetings with child care policy experts such as Professor Eileen Munro and Lord Laming;

I.9.8 **Phase 3c** – a public consultation, inviting contributions from the people of Jersey as to how Jersey can deliver a high-quality system of care for children;

[2] EE000136 Bullock Report

[3] Including Les Chênes and Greenfields

I.9.9 **Phase 3d** – a consultation with Jersey stakeholders from all sectors, which included discussions with the Panel, held in public session, in which contributors from other phases participated.

I.10 As part of Phase 3, the Panel consulted with members of past and present inquiries set up in the UK and other jurisdictions, including the Victoria Climbie, Rotherham, St Helena, Northern Ireland Historical Institutional Abuse and Scottish Child Abuse Inquiries, to discuss the challenges of translating Inquiry findings and recommendations into improvement in services for children.

Treatment and analysis of the evidence

I.11 Evidence was obtained by the Inquiry from various sources, including:

- disclosure from the Interested Parties;
- statements and documents provided by witnesses to the Inquiry;
- documents available to the general public;
- documents obtained from the Jersey Archive;
- all independent investigations and reports conducted in response to the concerns raised in 2007;
- information that came to light during the development and progress of the Redress Scheme.

I.12 In accordance with the Inquiry protocols, evidence given directly to the Inquiry was provided through a witness statement and then, in many cases, through oral evidence. Such statements and oral evidence were provided in three forms:

- **Publicly** – whereby individuals gave evidence under their own name, in the Inquiry's hearing room, in the presence of the Panel, the Interested Parties and the general public;

- **Anonymously** – whereby individuals (whose names were known to the Panel) gave evidence from behind a screen in the Inquiry's hearing room, in the presence of the Panel, Interested Parties and the general public, but with their name and identifying details redacted. Only Counsel to the Inquiry and the Panel could see the witness;

- **Privately** – whereby individuals gave evidence under their own name in the Inquiry's hearing room, in the presence of only the Panel and Counsel to the Inquiry. As neither the Interested Parties nor the general public were able to hear this evidence, it has been considered by the Panel only as background material and will be neither set out in this Report nor used when making findings. I should make it clear that nothing emerged in these private hearings that raised new lines of enquiry.

I.13 Oral evidence at the Inquiry's hearings was adduced by inquisitorial questioning by Counsel to the Inquiry. Relevant questions raised by Interested Parties were also asked on their behalf by Counsel to the Inquiry. There was no cross-examination. The members of the Panel were free to – and did – ask questions.

I.14 Some former residents of children's homes and foster care were not able or willing to give direct evidence to the Inquiry during Phase 1a. We considered, in many such cases, the witness statements provided by them to the States of Jersey Police, applications made by them to the Historic Redress Scheme, Social Services records, and documents produced by the Education Department or the Health and Social Services Department, such as memoranda and committee minutes.

I.15 In the case of witnesses giving evidence during Phase 1b, the Inquiry had access to statements made to the States of Jersey Police, police officers' reports, HR records and other contemporaneous documentation.

I.16 In the case of non-oral evidence, and when considering the weight, if any, to attach to it, I am mindful of the fact that this evidence was not tested or amplified in oral hearings.

I.17 Witnesses who gave evidence during Phase 1a and Phase 1b were asked, as envisaged by Term of Reference 7, to explain or comment upon individual allegations of abuse that they had made, or that had been made against them. Notwithstanding that fact, it is not our task to resolve factual disputes in relation to individual allegations of abuse. A public inquiry is not equipped for such a task: witnesses, whether accused or accusing, do not have the opportunities or the protections that would be necessary for such a process.

I.18 What is within our remit is to make findings about patterns of abuse, about systemic failings, and about the culture within particular institutions.

I.19 It has been necessary to devise a system naming individuals entitled to anonymity. The working presumption was that all of those giving evidence who had previously been children in care, and all of those who had worked in residential care facilities, were entitled to anonymity. This was on the basis that they were, or might be, individuals making allegations of abuse, or that they might be individuals accused of abuse. That presumption could be rebutted when such an individual gave evidence in public to the Inquiry, at which point his or her name could be used, in accordance with the Inquiry's protocols. Other factors affecting anonymity included the death of any individual or the fact that allegations against them were already in the public domain.

I.20 Ciphers have been used in cases where it was agreed by the Inquiry that a person could give evidence anonymously. They are also used where a person has been accused of abuse but is still alive and has not been convicted, or where the allegations are not in the public domain. The use of the cipher "WN" followed by a number does not indicate that allegations of abuse have been made against that person.

I.21 The following abbreviations are also used: "WD" (witness document) and "WS" (witness statement).

I.21 The Terms of Reference, drafted by the States, are broad in scope.

The Committee of Inquiry ("the Committee") is asked to do the following:

1. **Establish the type and nature of children's homes and fostering services in Jersey in the period under review, that is the post-war period, with a particular focus on the period after 1960. Consider (in general terms) why children were placed and maintained in these services.**

2. **Determine the organisation (including recruitment and supervision of staff), management, governance and culture of children's homes and any other establishments caring for children, run by the States and in other non-States run establishments providing for children where abuse has been alleged, in the period under review and consider whether these aspects of these establishments were adequate.**

3. **Examine the political and other oversight of children's homes and fostering services and other establishments run by the States with a particular focus on oversight by the various Education Committees between 1960 and 1995, by the various Health and Social Services Committee is between 1996 and 2005, and by ministerial government from 2006 to the current day.**

4. **Examine the political and societal environment during the period under review and its effect on the oversight of children's homes, fostering services and other establishments run by the States, on the reporting or non-reporting of abuse within or outside such organisations, on the response to those reports of abuse by all agencies and by the public, on the eventual police and any other investigations, and on the eventual outcomes.**

5. **Establish a chronology of significant changes in childcare practice and policy during the period under review, with reference to Jersey and the UK in order to identify the social and professional norms**

under which the services in Jersey operated throughout the period under review.

6. **Take into account the independent investigations and reports conducted in response to the concerns raised in 2007, and any relevant information that has come to light during the development and progression of the Redress Scheme.**

7. **Consider the experiences of those witnesses who suffered abuse or believe that they suffered abuse, and hear from staff who work in the services, together with any other relevant witnesses. It will be for the Committee to determine, by balancing the interests of justice and the public interest against a presumption of openness, whether, and to what extent, all or any of the evidence given to it should be given in private. The Committee, in accordance with Standing Order 147(2), will have the power to conduct hearings in private if the Chairman and members consider this to be appropriate.**

8. **Identify how and by what means concerns about abuse were raised and how, and to whom, they were reported. Establish whether systems existed to allow children and others to raise concerns and safeguard their well-being, whether these systems were adequate, and any failings they had.**

9. **Review the actions of the agencies of the government, the justice system and politicians during the period under review, in particular when concerns came to light about child abuse and establish what, if any, lessons are to be learnt.**

10. **Consider how the Education and Health and Social Services Departments dealt with concerns about alleged abuse, what action they took, whether these actions were in line with the policies and procedures of the day, and whether those policies and procedures were adequate.**

11. **Establish whether, where abuse was suspected, it was reported to the appropriate bodies, including the States of Jersey Police; what action was taken by persons or entities including the police, and whether this was in line with policies and procedures of the day and whether those policies and procedures were adequate.**

12. **Determine whether the concerns in 2007 was sufficient to justify the States of Jersey Police setting in train "Operation Rectangle".**

13. **Establish the process by which files were submitted by the States of Jersey Police to the prosecuting authorities for consideration, and establish:**

    i. **Whether those responsible for deciding on which cases to prosecute took a professional approach;**
    ii. **Whether the process was free from political or other interference at any level.**

14. **Set out what lessons can be learned for the current system a residential and foster care services in Jersey and for third-party providers of services for children and young people in the island.**

15. **Report on any other issues arising during the Inquiry considered to be relevant to the past safety of children in residential or foster care and other establishments run by the States, and whether these issues affect the safety of children in the future.**

I.22 Chapter 1 of this Report sets out an overview of and background to the Inquiry; the Terms of Reference are addressed and recommendations are made in the chapters that follow. Additional material is provided in appendices as follows:

- Appendix 1: Chronology of Significant Events in Jersey Relating to the Inquiry's Terms of Reference
- Appendix 2: Histories of People who Experienced Care in Jersey

- Appendix 3: Recommendations from Witnesses, and other Contributors to the Inquiry, on the Future of Child Care in Jersey
- Appendix 4: List of Contributors to Phase 3
- Appendix 5: Glossary
- Appendix 6: The Bullock and Parker Report
- Appendix 7: Legislation Study by Richard Whitehead
- Appendix 8: Documents on Oversight and Operation of Children's Services
- Appendix 9: Education and Children's Services Department and Health and Social Services Department Policies, Procedures and Guidance
- Appendix 10: Terms of Reference

Frances Oldham QC
March 2017

CHAPTER 1

Overview – Background and Reasons for this Inquiry

1.1 In July 2003, a report entitled "Hardship Experienced by Children and Young People in Jersey" was published.[1] The report included a poem written by a 14-year-old child. The poem could have been written for this Inquiry.

LISTEN[2]

We cry for help
Do you hear?
No, you don't
Because we are still here

We all have rights
So, people hear
We say it loud
We say it clear
Why do we have to live in fear?

Tell us now
How you feel
About these situations
Listen, they're real

We don't want to scream
We don't want to shout
We just want
To put our point out.

1.2 It is an undoubted fact that, over the decades since the Second World War, children in the care of the States of Jersey have suffered physical and sexual abuse. Appendix 2 provides brief summaries of the evidence of the people

[1] Co-ordinating Committee of the Decade for the Eradication of Poverty: WD009384/5

[2] WD00984/13

who gave accounts of their experiences in the care system to the Inquiry in public sessions.

1.3 In making the formal apology on 6 December 2010, Jersey's Chief Minister acknowledged that the care system had failed those children in a serious way:

> "*On behalf of the island's Government I acknowledge that the care system that operated historically in the island of Jersey failed some children in the States residential care in a serious way. To all those who suffered abuse, whether confirmed by criminal conviction or not, the island's Government offers its unreserved apology."*

1.4 The Chief Minister's statement referred to historical abuse and what was to become this Inquiry was originally entitled "The Historic Child Abuse Inquiry". The Panel changed the name to "The Independent Jersey Care Inquiry". The reason for the change, apart from stressing our independence, was to avoid the perception that child abuse occurred only in the past. Experience tells us that child abuse is likely to be occurring now. We have to learn from the past and the present in order to inform the future – in this case, the future protection of the island's children.

1.5 We have conducted our work independently of the States of Jersey, independently of the Police and of the Judiciary, and independently of any other organisation or individual in Jersey. We are not partisan, and we favour no particular group or individual.

1.6 The problem of child abuse is, of course, not confined to Jersey. It has been recognised in most, if not all, jurisdictions. Policies have been changed, protocols introduced and other steps taken over the years, as informed thinking has addressed the problem. On the basis of the evidence before the Inquiry, Jersey has consistently lagged behind England, Wales and Scotland in its approach to child care. The steps that have been taken over the years have not resulted in significant change. Jersey has a long history of commissioning reports on its child care provision and then failing to implement recommendations, or implementing them selectively, and failing to address underlying problems.

1.7 Jersey was occupied by German forces from 1 July 1940 until 9 May 1945. The 9 May anniversary is enshrined in the island's calendar as "Liberation Day". The population of Jersey during the Occupation was approximately 40,000, with 12,000 people returning after the War. In addition to the influx to the island of returning children, a significant number of children were born out of wedlock during the Occupation. Following the island's liberation, many of these illegitimate children were placed in the care of the States of Jersey, creating pressures on what the evidence available to the Inquiry suggests was an already over-stretched residential child care population. Another feature of the post-War period was the migration of itinerant French seasonal farmworkers who brought their families with them, placing their children in care on an informal and temporary basis and paying for their board and lodging.

1.8 In England and Scotland, a major review of children's services was under way during the final year of the War. The 1946 Curtis Report in England and the Clyde Report in Scotland provided the framework for fresh legislation. The *Children Act 1948* introduced, in England and Wales, Children's Departments and Children's Committees, created a new role of Children's Officer and introduced specialist child care officers. The Act placed greater emphasis on the social welfare of children.

1.9 By the 1950s, the UK[3] had recognised the detrimental effect of institutional care on the very young.[4]

1.10 The States of Jersey's provision of care appears to have remained largely unchanged until 1957,[5] when the Home Office was noted to have "*expressed anxiety about the lack of a Children's Committee in the island*". In *Education in Jersey 1952–1970,*[6] the author John Le Marquand described the prevailing conditions in children's homes in Jersey in the early 1950s as "Dickensian": *"Boys and girls were uniformly dressed and deprived of many liberties*

[3] Unless otherwise specified, the "UK" refers to England and Wales. We have taken this approach for brevity, but note that Scotland and Northern Ireland often had different legislation, policies and approaches to child care

[4] See the Bullock Report: EE000136

[5] See EE000038/6: Tony Le Sueur statement, 28 July 2014

[6] Société Jersiaise Annual Bulletin 1999, pp.485–486 – see https://www.theislandwiki.org/index.php/Education_in_Jersey_-_Part_3

normally found in the average home in the island." The incidence of children in public care in Jersey was twice as high as that in in the UK. It was not until 1959 that the island's first Children's Officer, Patricia Thornton, was appointed. Her appointment followed a recommendation from the States' Education Committee[7] in the wake of the concerns raised by the Home Office.

1.11 In 1960, Haut de la Garenne (HDLG) was formed as an amalgamation of the Jersey Home for Boys (JHFB) and the Jersey Home for Girls (JHFG). The home was a large institution, providing residential child care both as a children's home and for children on remand.

1.12 In the early 1960s, Jersey established its first Family Group Homes (FGHs), with the intention of providing long-term residential child care in a non-institutional setting.[8] This mirrored the provision in England of cottage homes in the 1950s. The concept of the FGH was that an existing family would provide a home for children who would otherwise be in residential care. The Housemother was employed by the Education Department. Her husband was expected to undertake the role of father within the home but to maintain his employment outside the home. The specified number of children to live in each FGH was eight, plus the children of the Houseparents. As evidence placed before the Inquiry suggests, and as is set out in more detail further on in this Report, in our view the reality was that this arrangement was ill conceived and poorly implemented. It caused tensions, and recruitment of Houseparents became very difficult.

1.13 There were cases of sexual abuse within FGHs. In October 1989, Leslie Hughes, Housefather at Clos des Sables, was convicted of five counts of sexual assault against three girls in his care. This conviction did not lead to a wider investigation to ensure that safeguards were in place to protect children from abuse. In 1997, Alan and Jane Maguire were investigated by the States of Jersey Police following allegations of physical and sexual abuse during their time as Houseparents at Blanche Pierre FGH in the 1980s. Blanche Pierre FGH had closed in 1993.

[7] See WD005364, Memorandum with Regard to Child Welfare, May 1958

[8] In total, five were set up: the first in 1960, and the rest in 1964,1965,1967 and 1970

1.14 In 1981, the UK's Department of Health and Social Services carried out a review of Jersey's care provision. The inspectors, David Lambert and Elizabeth Wilkinson, made 99 recommendations for improvement. Of those recommendations, 20 were directed to HDLG. The inspectors said that HDLG should be replaced by "*more suitable alternative forms of provision*".[9] Following their report, a working party recommended a phased closure of the home. The home was finally closed in 1986, after being wound down over the preceding years. The inspectors identified factors in the social structure of Jersey that resulted in a high level of need for social work intervention. The island had a high incidence of marital breakdown, alcoholism and heavy drinking, and psychiatric illness. Housing and accommodation problems contributed to family stress.[10]

1.15 The *Children Act 1989* overhauled child care law in England and Wales. While Jersey established a Child Protection Team in 1989, the island did not introduce legislation equivalent to the *Children Act 1989* until 2002: the *Children (Jersey) Law 2002*. It came into force in 2005 – 14 years after the *Children Act 1989*. Even then, Jersey did not adopt guidelines equivalent to those that accompanied the *Children Act*. The Jersey law echoes the principle that "the child's welfare must be paramount", but, in our view, the thrust of it does not contain the same emphasis on the requirement for a multi-disciplinary approach.

1.16 In 1977, Les Chênes opened and took on the remand role previously fulfilled by HDLG. It was, in effect, a hybrid Approved School/community school with education. In the UK, the *Children and Young Persons Act 1969* had abolished Approved Schools.

1.17 In 2001, Dr Kathie Bull was asked to prepare a report on Les Chênes, following an incident of violence towards a member of staff. In her comprehensive report, Dr Bull was critical of almost all aspects of Les

9 WD007382, p.78

10 *Ibid*, p.17

Chênes.[11] She stated: "*The absence of qualified and experienced childcare professionals is not acceptable."*

1.18 In August 2003, the police were called to Les Chênes following an incident that involved two residents. This episode was followed by the commissioning of a report from Madeleine Davies, Head of Staff Services.[12] The report was damning and highlighted "*inappropriate and legally dubious methods of managing pupils"*.

Operation Rectangle

1.19 In September 2007, the States of Jersey Police launched Operation Rectangle. Initially, it was an investigation into historical child sexual abuse within the Jersey Sea Cadets before being expanded to include HDLG. The investigation became public in November 2007.

1.20 The investigation arose as a result of the concerns of officers within the States of Jersey Police. One officer, DC Derek Carter, worked on an investigation into a former Housefather at HDLG.[13] Another investigation involved a visitor to the Home.[14] DC Carter wondered whether there was a link between the two and whether unauthorised individuals had gained access to children at HDLG. When reviewing the files of HDLG residents, he noted that some of the names of those about whom complaints were made kept recurring. Other officers also brought to his attention further allegations of abuse at the Home. DC Carter discussed the issue with acting DI Hewlett and they agreed that they needed to investigate HDLG, otherwise "*the complaints would keep coming and never go away*".[15]

1.21 In April 2006, DI Peter Hewlett submitted a report to the Chief Inspector of Crime Services, DCI André Bonjour. The report stated that "*rumours have been rife within the island for many years that Haut de la Garenne was notorious for the sexual, emotional and physical abuse allegedly handed out*

[11] WD004270 – Review of Principles, Procedures and Practices at Les Chênes Residential School

[12] WD004276

[13] Thomas Hamon

[14] WN264

[15] Day 104/117

to the residents". The report envisaged that any investigation would initially concentrate on HDLG but would have the potential to involve other homes. It also noted the possibility that suspects might still be working with children.

1.22 The report did not lead to any immediate action. We heard conflicting evidence about why that was, which is discussed in Chapter 10 below. The alleged delay led to an investigation by South Yorkshire Police.

1.23 In July 2007, the issue was revived by DCO Lenny Harper. A meeting was held between him, acting DI Peter Hewlett and DC Derek Carter. A number of key cases had been initially investigated years before, but resurfaced in 2007. Graham Power, who was appointed the Chief Officer of the States of Jersey Police in 2000, told the Inquiry:

> "… *the belief that there had been cases of child abuse which had not been properly addressed and the idea of 'cover-ups' to protect senior figures, had been a feature of island life for some years before I was appointed to the States of Jersey Police".*[16]

1.24 Other witnesses to the Inquiry highlighted additional factors that they said contributed to the establishment of Operation Rectangle: investigations into the Jersey Sea Cadets and Victoria College; a Serious Case Review in 2007; and the public perception, referred to by Graham Power, that sexual abuse had been covered up to protect senior figures.

1.25 Operation Rectangle commenced. As anticipated, it did expand to cover children in care at various institutions as well as those in foster care. Extensive excavation was undertaken at HDLG, and the investigation attracted worldwide, and sometimes lurid, publicity. The investigation identified 553 alleged offences against children; eight prosecutions followed, with convictions for 145 offences.

1.26 During Operation Rectangle, the Council of Ministers presented a report to the States of Jersey on 3 March 2008, stating that: "*the only way to ensure that there is total transparency is for a full public inquiry to be held in due course".* The Council said that, following the conclusion of Operation Rectangle, it would be:

[16] WS000536, paragraph 136

> *"essential to ensure that the terms of reference are far-reaching so that every concern expressed and every allegation made can be fully investigated. Whilst it may be too late to right the wrongs of the past it will be important for the people of Jersey that all relevant issues are brought out into the open so that the truth of what may have happened in recent decades can be established".*

1.27 Operation Rectangle formally closed in 2010. In February 2011, the Council of Ministers reviewed their previous commitment to hold a public inquiry. They concluded that the context within which they had made that commitment had "*changed beyond recognition*". The Council of Ministers reversed their decision to hold a public inquiry.

1.28 The decision was controversial and was debated by the States Assembly. On 2 March 2011, the States of Jersey voted by 31 votes to 11 to establish a Committee of Inquiry. The Council of Ministers agreed to "*reconsider a possible alternative way forward"*.

1.29 The Council of Ministers commissioned a scoping report from Verita, which they received in November 2011.

1.30 On 6 November 2012, the Council of Ministers lodged a proposition in the States Assembly, stating:

> "*The united view of this Council of Ministers is that a Committee of Inquiry is the right and proper way in which to proceed. It provides a clear acknowledgement that things have gone wrong in the past, and that now is the time to learn lessons from past failings in childcare provision. Ministers believe that by establishing a thorough, trusted and independent process of inquiry, the experience of all witnesses will be accorded their rightful importance and play a part in ensuring that Jersey has the correct framework to protect all islanders especially its most vulnerable*."

1.31 On 6 March 2013, all 38 members of the States Assembly then present voted in favour of the 15 Terms of Reference that formed the basis of this Inquiry.

1.32 While the debate regarding the establishment of a Committee of Inquiry was ongoing, the Council of Ministers announced, on 29 March 2012, the setting up of a compensation scheme for victims of historic abuse: the "Historic Abuse Redress Scheme". In order to qualify for compensation, applicants had to show that they were in the States of Jersey's full-time residential care

system "*at any time between 9 May 1945 and 31 December 1994 and that they had been subjected to sexual and or unlawful physical abuse"*.

1.33 When the Inquiry began hearing evidence in July 2014, the Scheme had received 132 applications. Of those, 125 claims ended with settlement agreements, three were withdrawn and four were rejected by the Scheme lawyer.

1.34 As part of the Inquiry's investigations, and following the issue of a summons, all applications to the Redress Scheme were disclosed to us.

1.35 While the Historic Redress Scheme brought some recompense to some people, it is not the whole answer. The need for this Inquiry is exemplified by two of the submissions made at the outset of our work.

1.36 The Jersey Care Leavers' Association said, in their opening remarks:

> "*Belated justice arrived in the Redress Scheme … But it is only part of the story and many did not seek compensation … For many there is still the sense of betrayal and of justice denied … This is a running sore that needs to be addressed."*[17]

1.37 The States of Jersey Police, in their opening remarks, said:

> *"Institutions and agencies in Jersey that may have missed past opportunities to stop abuse must now do all that they can to make procedures for safeguarding children and vulnerable adults as robust and rigorous as possible."*[18]

1.38 Throughout this Inquiry, the Panel has been constantly mindful of the responsibility it holds to the victims and survivors of abuse, and to those institutions and agencies now committed to providing and promoting robust and rigorous safeguarding for children and vulnerable adults in the island.

[17] Day 1/131

[18] Day 2/16

CHAPTER 2

Social, Historical and Political Background

2.1 In this chapter, we answer Term of Reference 4, which asks us to "Examine the political and societal environment during the period under review", and its effect on: (a) the oversight of children's homes, fostering services and other establishments run by the States; (b) the reporting of abuse; (c) the response to the reporting of abuse; and (d) the police and any other investigations.

Political background

2.2 Jersey is a Crown Dependency with its own Legislature, Executive and Judiciary. It has autonomy from the United Kingdom (UK) in all respects other than defence and foreign affairs. The legislature is the States Assembly, which currently has 49 elected members: eight Senators, 12 Connétables and 29 Deputies. It is headed by the Bailiff (who is unelected), whose office dates back to 1235. The Bailiff is appointed by the Crown after consultation within the island.

2.3 The office of Senator was created in 1948, and each Senator represents the whole of the island. Deputies are elected within constituencies that correspond with Parish boundaries. One Connétable is elected for each of the 12 Parishes. A Connétable automatically has a seat in the States Assembly. The Connétable of each Parish is head of the Honorary Police of that Parish.

2.4 The principal responsibilities of the States Assembly are to legislate and to appoint a Council of Ministers, Public Accounts Committee and Scrutiny Panels. The States Assembly also approves annual estimates of public expenditure and elects a Chief Minister from among its members. The Chief Minister nominates a Council of Ministers and the Assembly then votes on each proposed Minister. Under Jersey law, there are only 10 Ministers in addition to the office of Chief Minister.

2.5 The Bailiff is both the head of the States Assembly and the principal judge of the Royal Court. The Government of Jersey and the States Assembly are

given legal advice by the Attorney General (AG), who heads the Law Officers' Department (LOD). He is a member of the States Assembly "ex officio", although he has no right to vote. The AG is also the titular head of the Honorary Police.

2.6 The present ministerial system dates back to 2005. Before that, the Government of Jersey was run on a committee system, with committees for each State department. The Committee for Policy and Resources was the principal committee, with a role equivalent to that of the present Council of Ministers. The Civil Service in Jersey is headed by the Chief Executive of the Council of Ministers. Each department is headed by a civil servant known as a Chief Officer.

The "Jersey Way"

2.7 The Inquiry heard, in the course of the evidence, many references to the "Jersey Way". At its best, the "Jersey Way" is said to refer to the maintenance of proud and ancient traditions and the preservation of the island's way of life. At its worst, the "Jersey Way" is said to involve the protection of powerful interests and resistance to change even when change is patently needed.

2.8 Graham Power, former States of Jersey Police Chief Officer, said that part of the "Jersey Way" is "*never to do today what you can put off for ten years*". He said that, in the view of some, a disproportionate amount of power is concentrated in the hands of a few whose ancestors lived in Jersey for centuries and who are keen to maintain traditions and to resist "*Anglicisation*".[1] There was, in Mr Power's view, an "*old guard*" of those who resisted change in principle and some who said that if people did not like the way things were done in Jersey, they should move elsewhere.[2]

2.9 Former Deputy Trevor Pitman described the "Jersey Way" as *"the powerful, the establishment protecting the guilty and ensuring that those who probably should be held to account will not be held to account … it is about protecting the status quo … In a small community if you are part of a very entrenched*

[1] WS000536, pp.6-7
[2] Day 106/120

establishment and if there is a potential of it damaging Jersey's whiter than white reputation as a financial centre, you will not be held to account".[3]

2.10 Deputy Bob Hill said there was a "*culture of fear*" in Jersey, with people being afraid to come forward with information or criticisms of others who could have an influence over the informant's job or family. He believed that this culture impacted on child abuse investigations, as people were afraid to report abuse because they did not trust those to whom they might report to keep the information confidential. People did not question their betters or those in more senior positions. He said that Jersey residents had to keep quiet if they wanted to retain employment and security for their families.[4]

2.11 One anonymous witness told the Inquiry:

> *"We [also] have the impossible situation of the non-separation of powers between the judiciary and [the] political and there is a lot of secrecy, non-transparency and a lack of openness. This brings with it the lack of trust; the fear factor that many have spoken about, and contributes greatly to the Jersey Way."*[5]

2.12 In November 2008, the Howard League for Penal Reform produced a review that included the following at paragraph 10.7, under the note "Life in Jersey":[6]

> *"There can be an appearance of, or actual existence of 'cronyism'. Important decisions are made or believed to be made through 'old boys' networks'. Powerful interlocking networks may exclude and disempower those outside of the groups and make it hard for those outside of those networks who have genuine concerns to raise them or make complaints in an effective way. This is likely to be particularly true of deprived, disadvantaged and powerless children."*

2.13 Former Minister Ian Le Marquand said that unless there was a crisis in the public sector, resources would not be made available for improvements, "*as a general rule that certainly has been the position because of the pressure on priorities and so on. I think things did slightly improve under the last administration … but nevertheless as a general rule I'm afraid that the system is not very responsive*".[7] The priority for the States and the electorate was

[3] Day 109/7
[4] Day 104/5; WS000515
[5] Submission in Phase 3c of the Inquiry – 04.01.16
[6] WD007507/32
[7] Day 105/112-113

(and remains), he said, the maintenance of the low tax status on the island. In his experience, working in the public sector for 18 years, lack of funding was a recurring issue.[8]

2.14 In our opinion, it does not matter what view one takes of the "Jersey Way" because it can have no place in the formulation of policy or its implementation so far as children in care are concerned. Societies change their policies from time to time because they perceive problems in an existing policy or seek improvement from a new one. No-one would change a policy that was working well simply because it was well established. Likewise, no-one would defend a policy that was not working well just because it was well established. As the Chinese king Wuling observed in the year 307 BC: "*A talent for following the ways of yesterday is not sufficient to improve the world of today*."

Social and historical background

2.15 The Inquiry received evidence[9] which provided an overview of the "societal environment" (see Term of Reference 4) in which children were placed in residential or foster care and in which they may or may not have raised concerns about abuse.

2.16 David Lambert and Elizabeth Wilkinson (DHSS Inspectors), in their 1981 Report, encapsulated some of the factors affecting Jersey across this period in a passage from which a short extract has already been cited above:

> *"Whilst Jersey is clearly not an industrialised area, such as Newham or Salford, there may be factors in the social structure which amalgamate to produce families and children which attract social work intervention. There are indications that the island has a high incidence of marital breakdown, alcoholism and heavy drinking and psychiatric illness. Social workers also indicated that housing and accommodation problems also contribute to family stress and difficulty. The breakdown or absence of extended family networks also leads to isolation and insecurity. The island also has experience of managing migrant workforces for both the farming and hotel industries. Many of these migrant workers seek a more permanent residence on the island … Another contributing factor to the workload of the Section concerns the incidence of illegitimate births. Apparently, the number of girls coming*

[8] WS000648/2

[9] Witness statements/exhibits; census information; States of Jersey Police and Children's Services records; policy documents/reports and expert evidence

> *to the island on a temporary basis and becoming pregnant has lessened of late, but it still remains a consideration. Equally worrying is the growth of heavy drinking by juveniles and young people. The case files studie[d] during the course of this inspection showed many examples of these factors at work in individual families*."

2.17 We note that, despite having a population comparable to Lincoln or Basingstoke, Jersey is required to have the structures and institutions of an independent state, including its own Government, Legislature and public services. We note that, for various reasons, there have been almost constant budgetary pressures on those providing for children in care.

2.18 The evidence considered by the Inquiry suggests that the particular features of Jersey made it a unique environment for children growing up here: an insular community with a modest population, with a legacy of German occupation during the Second World War, split into 12 Parishes and policed in part by a voluntary police force, politically independent from the UK but with heavy reliance on it for legislative innovation.

The Parish system

2.19 Jersey is divided into 12 Parishes. Each Parish is headed by a Connétable (Constable) and governed by the Parish Assembly.

2.20 The Connétable of the Parish played a pivotal role as an officer of the Honorary Police in carrying out statutory duties in relation to children. He was responsible, for example, for approving foster parents,[10] although he had no formal training in that regard. The test for certifying fitness was simply one of whether the proposed foster parent was a "fit and proper person"; in effect, this amounted to whether the applicant was a good parishioner.[11] The Connétable could also make applications for admission of a child into care (for example, under the *Public Instruction Committee Acts 1946 and 1953*). In addition, he was responsible for the provision of "outdoor relief" under the Poor Laws. This was financial assistance provided by the Parish to those in need and funded from Parish taxation. The Connétable had considerable influence over parishioners who came into contact with him through his

[10] Loi sur la protection d'enfance 1940

[11] Day 5/104

financial, executive and policing functions. He wielded considerable power in the Parish and was subject to little or nothing in the way of checks and balances.

2.21 John Rodhouse, Director of Education (1973–1989) explained that, during his tenure, Jersey was not a welfare state. The primary source of aid for those out of work or unable to work was Parish Relief. The granting of relief was subject to the personal judgement of the Connétable and could not always be relied upon. There was no right of appeal from the decision of the Connétable. Relief was provided by the payment of cash and the provision of items such as clothing or domestic appliances.

2.22 As noted above, in January 1958, the Education Committee, the States' body then responsible for residential child care provision, convened a meeting to review arrangements then in place for the welfare of children. This was in response to concerns raised by the UK Home Office about the lack of a Children's Department in Jersey. The result was the creation of the Children's Committee and the appointment of the first Children's Officer, Patricia Thornton.[12]

2.23 Following the formation of the Children's Committee in 1959, the Parishes continued to fund the placement of children in care, based on a boarding-out rate for each child agreed by the Parishes. A boarding-out tariff was paid for each child to the "Children's Department".[13] The Connétable remained under a duty to report to the AG the case of any child who appeared to be in need of care, protection or control.[14]

The Occupation

2.24 Jersey was occupied by German forces from 1 July 1940 until 9 May 1945 (thereafter known as "Liberation Day").[15] The Medical Officer for Health (MOfH) reported on 18 January 1946 that the children of the island had

[12] EE000046

[13] Day 4/30 – the term "Children's Department" appears in records in the 1960s, although there was no formal department. The payments went to the Education Committee

[14] Pursuant to Article 28(2), Children (Jersey) Law 1969; LG000032/24. This provision was not replicated in the Children (Jersey) Law 2002; LG000033/13

[15] Richard Whitehead: EE000261/7

"*practically recovered to 1940 standards of height and weight, due to the abundance of food flowing into the island*" following the Liberation.[16]

2.25 The Inquiry had the benefit of evidence from a few individuals who were resident in children's homes during and immediately after the Occupation. Examples are:

- Malcolm Carver [Jersey Home for Boys (1944 and 1946–1951)] recalled "*war kids*" (presumably returnees to the island) "*pouring in*" to the Jersey Home for Boys (JHFB). There were only three members of staff (excluding gardeners and the cook), who were all ex-servicemen. He described a degree of bullying by older boys.[17]

- Giffard Aubin [Jersey Home for Boys (1941–1951)]. He complained of the lack of staff, the effect being that the boys were "looked after" by senior boys who bullied the vulnerable.[18]

- Malcolm Doublard [Jersey Home for Boys (1942)]. He was placed at the JHFB in 1942, when his father was taken prisoner by the Germans and his mother could not cope on her own, having been denied "outdoor relief" by the Connétable of St Ouen.[19] He vividly recalls the home being clean, but the food being terrible.[20] He also described the restrictions on the boys' freedom, as the adjacent field was used by the Germans for gun practice, and the boys could not go out when they were practising.[21] He described severe bullying by older boys. Electrodes were used to administer electric shocks to the younger boys.[22]

2.26 In his evidence, Tony Le Sueur commented upon the issues facing Jersey after the Occupation.[23] He noted that "*managing the reality of babies born during the Occupation who have been classed as illegitimate and whose parentage may have been in question*" was a particular issue. The Westaway

[16] WD004847/9
[17] Day 9/124
[18] Day 8/15 WS000001
[19] WS000093/2 and Day 22/45/25
[20] Day 22/4/9
[21] WS000093
[22] Day 22/51
[23] Policy Development Governance and Quality Assurance Manager; Day 4; EE000038/12

Crèche, the most likely recipient of unwanted illegitimate children, received an average of 28 admissions per year during the Occupation.[24] In addition, significant numbers of children were returning to the island after the War. Some of these children may have been orphaned, and this no doubt placed an additional burden on States provision for children at that time.

2.27 The end of the Occupation saw legislative reform in relation to children, in particular the enactment of the *Adoption of Children (Jersey) Law 1947*. In his statement, Richard Whitehead[25] said that the timing of the law might support anecdotal evidence that the trigger was the number of illegitimate births during and after the War. The rationale for this law was to give assurance to adoptive parents "*that the care, expense and attention which they give to the adopted child will not be lost and that the natural parent will not step in whenever it suits him to do so"*.[26] Mr Whitehead said that this specifically related to the post-War situation where families, having taken in illegitimate children, lived in fear that the purported father might try to reclaim the child.

2.28 At the time of the formation of the Children's Committee at the end of the 1950s, John Le Marquand, in his *History of Education in Jersey (Part 3)*, noted that: *"It came very much of a shock to realise that the number of children in public care in Jersey was twice as high as the average figure for children's authorities in the United Kingdom."*[27]

The population of Jersey

2.29 Tony Le Sueur told the Inquiry that the population during the Occupation was of the order of 40,000, with 12,000 returning after the War.[28] He explained that a particular feature of post-War Jersey was the presence of itinerant farmworkers from France, who came to Jersey on a seasonal basis to work in agriculture. They brought their children with them, but without any provision for their care. The children were placed on an informal and temporary basis at

[24] EE000038
[25] Principal Legal Adviser, Law Officers' Department
[26] EE000261
[27] http://www.theislandwiki.org/index.php/Education_in_Jersey_-_Part_3
[28] Day 4/21

Haut de la Garenne (HDLG), with board and lodging funded by the workers.[29] Tony Le Sueur said that the employment of the immigrant workers moved away from farming to tourism, notably from the 1960s.

2.30 In recent times, the Portuguese-speaking community (principally from Madeira) has contributed a significant proportion of Jersey's immigrant population (8.2%, according to the 2011 census). Tony Le Sueur said that a particular feature of the Madeiran population is the use of the extended family to look after the children rather than relying on States' provision. A consequence of this was a likely under-reporting of private fostering arrangements. By contrast, it was noted in the recommendations from Dr Kathie Bull's Report of December 2002 that one of the challenges for many parents in Jersey was a lack of familial support from extended family.

2.31 The Inquiry has seen records relating to the children of Irish parentage accepted into care, particularly in the early decades of the period under review. As with other nationalities, the reasons given for acceptance into the States' care included poor/overcrowded housing, alcohol abuse, domestic violence and problems arising from unstable domestic circumstances including the illegitimacy of the child in question. In their 1981 Report, Lambert and Wilkinson commented on the number of girls coming to the island on a temporary basis, becoming pregnant and then remaining in Jersey.[30]

2.32 In terms of population, Jersey is comparable to Lincoln or Basingstoke,[31] but it is required to have the apparatus of an independent state, with its own Government, Legislature and public services. Jersey has markedly lower taxation rates than the UK.[32] A considerable number of witnesses, including politicians, Children's Services Managers and civil servants, described the constant budget pressures that they faced in providing for children in care.

[29] Day 5/18
[30] WD007382/17
[31] WD007100/860
[32] A maximum of 20% income tax; standard rate of 0% company tax (excluding financial service and utility companies)

Housing

2.33 One effect of Jersey's population density is competition for housing. There are laws that govern the entitlement to available properties.[33] Jersey has a system of "qualification" to entitle access to various parts of the housing stock. A citizen has to reside in Jersey for a significant period[34] before he or she can gain access to certain housing, including accommodation provided by the States.

2.34 It is clear from the evidence given to the Inquiry that the availability and cost of housing presented considerable difficulties for families in the period under review. Inadequate housing is cited in numerous Education and Health and Social Services Department records as a reason for the admission of a child into care. It often formed part of a background of deprivation, along with unemployment, alcoholism and domestic abuse.[35]

2.35 In some cases, the bare fact of lack of accommodation was the reason for admission into care. One example is the case of sibling witnesses WN391, WN383 and WN385, admitted to Brig-y-Don and then HDLG in the early 1970s. "*Temporary homelessness*" was the reason given for admission.[36] Two and a half years later, they were still there. A case conference in March 1975 indicated that the family had been *"more or less blacklisted by the Housing Department*".[37] A letter from Children's Services to the Housing Officer concluded:

> *"I would stress that these children are in the care of the States of Jersey Education Committee solely as a result of accommodation difficulties and I would therefore be grateful for any urgent consideration that could be shown towards this particular case before further serious damage is caused to the development and future welfare of this young family."*[38]

[33] EE000038/20
[34] Currently 10 years; previously 19 years
[35] E.g. RS000613/25
[36] Day 52/67
[37] WD003541
[38] WD003554

2.36 Another example is provided by WN99 and his siblings. In September 1977, they were said to be remaining in care "*mainly due to housing difficulties*".[39] WN99 was in HDLG for over 10 years. Both he and his siblings made allegations of abuse about their time in care.

2.37 The result was that, by reason only of housing difficulties, some children spent long periods in residential care, some of whom may have suffered abuse and deprivation.

2.38 These are not isolated examples. There are several references in the evidence to children being sent to residential homes because of a lack of housing or inadequate accommodation.

2.39 Restrictive practices by landlords appear to have been a factor in the lack of accommodation for families. Even as late as 1988, some landlords on the island adopted a "no kids" rule for let premises, as reported by the JEP in February of that year.[40] Thus, the already small pool of housing grew even more diminished.

2.40 The quality of housing for poor families was also a feature of the "*societal environment*" during the period under review. In many of the Children's Services files, reference is made to inadequate sanitation, lack of running water and overcrowded or shabby accommodation, with families living in one or two rooms. Overcrowding remained a significant factor in Jersey, and the 2001 census noted that overcrowding affected 2,684 people.[41]

2.41 In July 2003, a report entitled "Hardship Experienced by Children and Young People in Jersey"[42] was published. It stated:

> "*Circumstances that increase the risk of hardship appear similar to those in the UK (unemployment, lone parents, the sick and disabled and large families). Aspects that are more prominent in the island include the influence of inadequate and costly housing and the high cost of living in general and the effect his has on the work/life balance*."

[39] WD002788
[40] WD000383
[41] WD009384/15
[42] Co-ordinating Committee of the Decade for the Eradication of Poverty; WD009384/5

2.42 The 2003 Report noted that the States provided financial assistance to the residentially qualified. This was by way of mortgage interest relief, loans for first-time buyers, private-sector rent rebates, public-sector rent abatement and through the Housing Development Fund. An estimated 20% of Jersey residents did not have residential qualification. The vast majority lived in lodgings, with no security of tenure. Many of the lodgings were described as "unsuitable for family life". Rent accounted for between 50% and 70% of income.

2.43 Professor Roger Bullock, in his expert evidence to the Inquiry,[43] said that overcrowding is known to produce depression, which results in poor parenting, which then produces behavioural problems in children. Lambert and Wilkinson also noted that housing pressures are likely to contribute to family stress and difficulties. They highlighted that this was a particularly acute problem when Children's Services sought to place siblings together with a single set of foster parents.[44] Potential foster parents often did not have a spare bed, let alone a spare room for a child.

2.44 In 2003, Tony Le Sueur, in his role as Children's Services Manager with responsibility for Adoption and Fostering Services, produced a report entitled "Housing Issues Affecting Children in Care and Children in Need",[45] which is a useful summary of the impact on young children at that time. The key points were:

- 16-year-olds who no longer wished to remain in residential care were not entitled to Parish Welfare or Rent Rebate until the age of 17, and were not eligible for bedsit accommodation from the Housing Department, so it was left to Social Services to try to secure private accommodation;
- 17-year-olds trying to access accommodation could apply for Parish Welfare or States-provided accommodation, but would have to demonstrate that they had no surviving relatives who could provide accommodation;

[43] Day 7/137; EE000136/50
[44] WD006122
[45] WD008733

- for families without housing qualifications, the only options were to take the children into care, or to fund the family in B&B accommodation – the former costing up to £40,000 per annum – and there being no funding for the latter;

- there was a shortage of residential accommodation for children.

2.45 The Report concluded that greater co-operation was needed between the Housing Department and Children's Services, with the former accepting its responsibility as "*corporate parent*" for children in care.

2.46 Pressure on housing also impacted on employees of Children's Services. Posts that attracted workers from outside the island were either those with accommodation provided (such as HDLG) or those where individuals were classed by the Housing Committee as "*essentially employed*".[46] At times, and for certain posts, recruitment by Children's Services was limited to Jersey residents, and in some instances Jersey residents were favoured over UK applicants because accommodation did not have to be provided or subsidised. The tie between accommodation and work is significant.

2.47 As Dylan Southern (Director of Nursing and Mental Health) explained to the Inquiry, *"some people, if they lost their job here, would lose their housing, their status and they would have to leave the island".*[47] Kevin Mansell, the former Principal of Les Chênes, stated that one of the reasons that he did not resign, despite being repeatedly blocked by the Education Department in requests for more staff and greater resources, was that he lived on site and, if he had resigned his job, he would have had nowhere to live.[48]

2.48 If accommodation was not provided by the employer, individuals from outside Jersey were only able to secure accommodation if they were regarded as "essentially employed" staff. In this respect, the Inquiry has heard evidence that:

- as at July 1977, only staff with residential [care] qualifications were regarded as "essentially employed". Nurses were regarded as "essentially employed"

[46] WD002616, WS000612, WS000629
[47] Day 116/110
[48] Day 80/78/4

so long as they remained in the employment of the Public Health Committee, and staff at Les Chênes were also accorded the status of being regarded as such. It would appear that staff at HDLG were not considered as "essentially employed";[49]

- in October 1979, an Act of the Education Committee noted that, from that point, all child care officerss recruited from the UK were only to be considered for housing under the leasing arrangements included in the Assisted House Purchase Scheme and were not to be regarded as "essentially employed" in the same way as certain teachers were;

- status was determined by the Housing Committee, who refused to give this status to many posts within the Education Committee's service in the 1980s;[50]

- even those who were classified as being essentially employed were still limited as to which properties they could rent and were not able to purchase property for a prescribed period of time.[51]

2.49 The housing situation was also central to the issue of recruitment of staff in residential children's homes. Geoffrey Spencer (Officer in Charge of Heathfield from 1987) told the Inquiry that the management at Heathfield recruited more people from Jersey than from the UK because of the housing issue. This was an unsatisfactory state of affairs because most employees from Jersey were not qualified, whereas those from the UK were qualified.[52] Mr Spencer's own letter of offer of appointment in April 1987 stated in terms: "*Housing: this is the most difficult issue which faces you in taking an appointment in Jersey*."[53]

2.50 Phil Dennett (Health and Social Services Department) said that the costs associated with recruiting from the UK were prohibitive (in terms of subsidising accommodation).[54] He stated that UK employees would often

[49] WD002616
[50] WS000612/18
[51] WS000629/16
[52] Day 75/25
[53] WD006417/25
[54] Day 95/99

move on very quickly due to the high cost of living in Jersey, particularly the cost of renting. There was therefore pressure to recruit applicants already resident in Jersey. On the retirement of Charles Smith (Children's Officer) the Housing Committee did not allow the post to be advertised outside Jersey. There was pressure to promote Anton Skinner, who was born in Jersey. In the event, he was appointed, but only on completion of a placement in the UK to gain relevant experience.[55]

2.51 John Rodhouse (Director of Education 1973–1989) also complained that restrictions put in place by the Housing Department, throughout his period in Jersey, made recruitment very difficult. He told the Inquiry that, in the late 1970s and throughout the 1980s, there was concern about the growth of the island's population and there were real attempts to restrict growth.[56] He stated that this resulted in appointments being made from a limited field and that those appointed were not always the best candidates for the job.[57] Throughout the 1980s, he was not permitted to recruit primary school head teachers from off island as they would not have been given *"essential employee*" status at that time (and would therefore face difficulties in obtaining accommodation).

2.52 These recruitment problems persist. Tony Le Sueur told the Inquiry that the cost of living remains very high in Jersey and that this negates the attraction of the relatively high salaries in the island.[58] He indicated that the high cost of accommodation was central to the problem of recruiting skilled workers to Children's Services from abroad.

Impact of financial pressures

2.53 Many of the Children's Services historical files record that both parents were in some form of employment, with difficulties arising due to parental absence and lack of supervision. This was particularly so in cases where there was no extended family to care for the children. Lambert and Wilkinson noted in 1981 that many nurseries accepted babies from the age of two or three months

[55] Day 95/202
[56] Day 92/47/25
[57] Day 92/48
[58] Day 89/178

because, if Parish Relief was declined, mothers had no alternative but to find work and place their baby in childcare.[59]

2.54 Jersey is known for its very high percentage of women in work.[60] A report in 2003[61] said that hardship to children in Jersey derived from costly and inadequate housing, parental stress from long working hours and fear of taking time off when children were unwell. The lack of after-school and holiday care and the cost of living was also noted.

Social divisions

2.55 A notable feature of the evidence considered by the Inquiry is the perceived gap between the rich and the poor in Jersey. The social division is not limited to disparities in financial status but also relates to disparities in power and influence. A recurrent theme in the evidence is the description of a culture of "*them and us*". A self-selecting powerful elite, referred to as the "*Establishment*", is said to maintain the control of areas such as voluntary policing, the Parishes, politics and the media.

2.56 The authors of the 2003 Report[62] noted the particular difficulties of being poor in Jersey, with Jersey's affluent society stimulating aspirations beyond people's means:

> *"In addition to the economic pressure on parents caused by the high proportion of income needed for fixed costs of rent and child care, Jersey's affluent society stimulates aspirations beyond means. As one participant put it, 'Here noses are pressed hard against shop windows' … This increases parental stress, especially for those who work very hard and still feel guilty that they cannot provide their children with what 'everybody has' according to them."*

2.57 In his evidence to the Inquiry, Anton Skinner[63] described Jersey as an affluent island with enormous poverty.[64] In his view, "*up until recent times*", there was a patrician type of community, with the great and the good deciding how the

[59] WD007382/73

[60] See "Children and Young People: a strategic framework for Jersey" (2011) – WD007100/860

[61] WD007100/852-860

[62] WD009384/16; "Hardship experienced by Children and Young People in Jersey"

[63] Children's Officer, 1986–1995; Director of Community and Social Services, 1996–2002

[64] Day 87/39–40

"*poor and feckless*" should be dealt with, saying "*it wasn't an impressively democratic society*".

Reporting and non-reporting of abuse

2.58 The perceived "*them and us*" culture, with its origins in divisions of wealth and power, as well as demonstrating a failure to understand the true causes of social inequality, appears to have been a powerful disincentive to report incidents of abuse, whether physical, sexual or emotional. The fear, on a small island, that the person complained about might be connected to the person to whom the complaint was being made would add to that disincentive – and the more if it would have consequences for employment and accommodation.

Findings: Social, historical and political background

2.59 We consider that an inappropriate regard for the "Jersey Way" is likely to have inhibited the prompt development of policy and legislation concerning children.

2.60 Parish Relief depended upon the personal judgement of the Connétable. No welfare net was provided by the States. Over a substantial period, the Connétable played an important role with regard to children in care, including the certification of foster parents, making applications for admission of a child into care, and reporting to the AG if any child appeared to be in need of care, protection and control. We have not seen any evidence of Connétables receiving training for any of these roles.

2.61 The shortage and cost of housing has had a marked impact on fostering in Jersey, with some potential candidates having insufficient space to accommodate foster children. We note that, at present, fostering couples have no priority in terms of access to States' housing. Also, it is not a requirement that a fostering couple have one parent remaining at home. This reflects the fact that both are likely to be in work due to the high cost of living in Jersey. We consider that this has had a detrimental effect on the ability of Jersey to provide adequate fostering provision for children in care, although we acknowledge that the amount of provision has varied over the years.

2.62 In our view, pressures on accommodation in Jersey did have a detrimental effect on the ability of the relevant departments to recruit and retain suitably qualified and trained child care staff from outside the island. This led to the recruitment of more people from within Jersey, who were often less qualified and experienced.

2.63 The strong ties between accommodation and work, whereby individuals often either were provided with accommodation (for example, by HDLG) or needed to be employed in order to retain their accommodation (i.e. if classified as "essentially employed"), had an inhibiting effect on their ability to raise concerns.

2.64 On the basis of the evidence received by the Inquiry, we have noted a recurrent theme of social and economic disparity. Jersey appears to have relied heavily on private and/or voluntary intervention in its role in providing for children in care, and overseeing that provision.

2.65 In our view, the Housing Department did not, at any time, accept or discharge the role that it had to play in the States of Jersey's responsibility as the "corporate parent" of children in care.

2.66 We note that Term of Reference 4 asks us to examine the effect of the political and societal environment in Jersey on specific issues found elsewhere in the Terms of Reference on various issues. We have approached this task by considering such effects in the following chapters:

- effect on oversight of children's homes, fostering services and other establishments run by the States – Chapter 5;
- effect on the reporting or non-reporting of abuse – Chapter 8;
- effect on the response to reports of abuse – Chapter 9;
- effect on the Police and other investigations – Chapters 10 and 11.

CHAPTER 3

The Type and Nature of Children's Homes and Fostering Services; and the Reasons why Children were Placed and Maintained in these Services

Introduction

3.1 In this chapter, under Term of Reference 1, we establish the type and nature of children's homes and fostering services in Jersey, with a particular focus on the period after 1960. No findings are made on this topic, as the evidence itself fulfils this part of the Term of Reference. We also consider, in general terms, why children were placed and kept in care, and make findings accordingly.

3.2 The provision of children's homes during the period under review was split between homes run by the States of Jersey and those run by the voluntary or charitable sector. Some of the homes evolved in their nature, starting as voluntary institutions and later coming under States' provision. Brig-y-Don and La Preference are two such examples. Some homes remained under the control of the States of Jersey but evolved in their constitution or use; for example, Jersey Home for Boys (JHFB) merged with the Jersey Home for Girls (JHFG) and in 1959 became known as Haut de la Garenne (HDLG).

3.3 Fostering services were historically split between what was known as "boarding out" and what is referred to as "fostering". The former was the placement of children, in the care of the States of Jersey, with foster families. Fostering was the placement of children on a private basis by the birth family with another family. This distinction is somewhat confused by the fact that "fostering" was often used to describe both, and in the modern era "fostering" has been the accepted parlance to describe both types of arrangements.

Children's homes

Jersey Home for Boys

3.4 The home was built in 1866 in the Parish of Gorey and was known as the Jersey Industrial School until 1900, when the name was changed to Jersey Home for Boys.[1] It originally catered for 45 boys, and records show 142 admissions during the German Occupation. The Public Instruction Committee was responsible for the JHFB from 1922 onwards.

3.5 The *1935 Loi* enabled children under 14 to be sent to the Home if they had committed an indictable offence or were "in need of protection", until they were 16.[2] The *Public Instruction Committee Act 1946*[3] set out that boys between six and 15 years of age were to be admitted to the Jersey Home for Boys "*and will normally remain there until they attain school leaving age*". A boy admitted "*by order of the Royal Court*" was to remain there until "*the Court has sanctioned his leaving the Home to take up suitable employment".*

3.6 In May 1958, the Education Committee recommended that the JHFB and the JHFG be amalgamated. There were "*rather more than 40*" residents at the JHFB, and it was noted that most children were admitted at the direct request of the Connétable of the Parish rather than being committed by the Royal Court.[4]

3.7 In 1959, the Education Committee approved a scheme for the reconstruction of the Jersey Home for Boys to accommodate a maximum of 35 boys and 10 girls. This was to include temporary accommodation for some children remanded by the Royal Court and facilities for a small number of babies under the age of two years. As at January 1968, there were 67 children in the Home (51 boys and 16 girls).[5]

[1] WD007012/59

[2] EE000261/4

[3] EE000255

[4] WD005364/40

[5] WD004915

Jersey Home for Girls

3.8 Jersey Home for Girls was set up as the Jersey Female Orphans Home in 1862, in the Parish of Grouville.[6] From 1933, the JHFG gained "semi-official status", in that the Royal Court was empowered to send children there as an alternative to being sent to an Approved School in the UK (as was the case with the JHFB).[7] Until 1939, the institution was run by the "Trustees of the Jersey Female Orphans Home", at which point the property was ceded to the States of Jersey to "*ensure that young girls will in the future receive the same high degree of comfort and advantage as is now, and has been for many years, received by boys at the Jersey Home for Boys"*.[8]

3.9 The *Public Instruction Committee Act 1946* set out that girls between the ages of six and 12 years should be admitted to the JHFG "*and will normally remain there until they attain the age of 17*". In May 1958, there were "*rather fewer than 20*" residents at the JHFG – most admitted at the direct request of the Connétable rather than being committed by the Royal Court.[9]

3.10 The JHFG closed in 1959, when it was amalgamated with the JHFB, and subsequently became known as Haut de la Garenne. The *Jersey Female Orphans Home Law 1961* authorised the transfer of remaining trust funds to the States, reflecting the policy of placing in HDLG those boys and girls who could not be boarded out.[10]

Westaway Crèche

3.11 The Westaway Crèche was established in 1934, in the parish of St Helier, as "*a Crèche and day nursery for babies so that widows could go out to work*". From 1941, the Crèche routinely housed orphans and abandoned babies before they were placed with a foster family or moved to the JHFB or JHFG.[11]

[6] EE000038/3
[7] EE000152/3
[8] EE000152/6
[9] WD005364/5
[10] EE000173
[11] EE000038/4

3.12 The Crèche operated as a private organisation until 1940, when it became the responsibility of the Education Committee. By December 1947, the Public Instruction Committee was the sole authority responsible for the care of "*deprived children*", including those at Westaway. The *Public Instruction Committee Act 1946*[12] set out that children under six years of age were to be admitted to the Crèche.

3.13 The majority of those admitted to the Crèche were short-stay cases[13] and the capacity appears to have been for about over 40 children,[14] although less than half of that number were in residence at various points over the next decades.[15]

3.14 The May 1946 minutes of the Public Instruction Committee note that the Crèche was overcrowded, with 48 residents, and was also understaffed. In January 1948, an inspection by members of the Public Instruction Committee noted 46 children resident; four months later, it described the Crèche as "*full to capacity*" and rejected several applications for admission.[16] Three months later, the minutes note that 11 children from the Crèche left the island under a South African adoption scheme. This presumably alleviated the pressure on capacity. In August 1958, a Senator on the Public Instruction Committee inspected the premises and reported that they were "*totally unsatisfactory*".[17]

3.15 The Crèche was staffed by nursery nurses. In November 1955, two nurses resigned in protest at the treatment of children placed at the Crèche and at staff working conditions. The Public Instruction Committee investigated and concluded that there was no definite evidence of cruelty to children. Two boys had been punished in isolation for three or four days and nights. It was noted that this was not a proper punishment for small children. What is not clear from the entry in the minutes is whether the criticism is of the use of isolation within the home or its duration. One of the boys was referred to the Child

[12] EE000255

[13] EE000255/1

[14] Day 144/111

[15] E.g. EE000052/2

[16] Day 144/111

[17] Day 144/112

Guidance Clinic – a recognition, perhaps, that the more appropriate management of challenging behaviour was not punishment but treatment.

3.16 A report in October 1964 on the need for a nursery at Haut de la Garenne noted that the "mixing of children" was not harmful and was something positively beneficial to more disturbed children.[18]

3.17 Although the States of Jersey approved the closure of Westaway Crèche in 1959, as it was due to be amalgamated with the JHFB and JHFG as part of the new HDLG, it remained open until February 1966, when the terms of the original trust were amended. At this point, staff and babies from the Crèche moved to the "Westaway Wing" at HDLG and the Crèche became a day nursery for some time.[19] One of the perceived advantages of the amalgamation was that members of large families could all be placed in the same children's home.[20]

The Sacré Coeur Orphanage

3.18 The Sacré Coeur Orphanage was established in 1901, in the parish of St Helier, to be used as a convent for French Catholic nuns and an orphanage for Catholic children.[21] By 1904, 78 primary-school-age children and 13 babies were living on site with nine Catholic sisters.

3.19 The Inquiry heard from former residents and staff members that the institution ran alongside a textile/knitwear factory known as "Summerland", in which children worked.

3.20 In May 1958, the Director of Education noted that there were 66 children at Sacré Coeur and it was "*not subject to public supervision or inspection*", which, as below, did not change until 1969.[22]

3.21 Sacré Coeur received a mixture of children placed privately, and those who were in care, for whom it received a boarding-out allowance, although the

[18] WD006912

[19] EE000038/9

[20] WD004582/4

[21] Sacré Coeur: Catholic order: Congregation de la Sainte-Famille d'Amiens

[22] WD005364/4

former appear to have constituted the large majority of residents.[23] Sacré Coeur also operated a nursery, which was registered in May 1970 under *Article 68 of the Children (Jersey) Law 1969*.

3.22 Although Tony Le Sueur gave evidence suggesting that Sacré Coeur closed its residential provision in the mid to late 1960s,[24] the evidence about registration and the evidence of WN327[25] and WN807[26] suggest that full-time care ceased around 1972.

Haut de la Garenne (1959–1969)

3.23 Haut de la Garenne was formed as an amalgamation of the JHFB and the JHFG (and subsequently the Westaway Crèche).[27]

3.24 It was located in the former premises of the JHFB, in the parish of Gorey, and, by September 1959, all the girls from the JHFG had been transferred to HDLG. The Home had three different names until the States of Jersey changed the name of the institution to Haut de la Garenne in 1960.[28]

3.25 When the formation of the Home was first proposed in May 1958, it was intended to serve five separate purposes:[29]

- Function 1 – a long-stay home for those who were not suitable for boarding out in "*cottage homes*";[30]
- Function 2 – a short-stay home for children – for example, those whose mothers entered hospital for a few weeks;
- Function 3 – to accommodate very young children who could not be boarded out and who were too young for cottage homes (i.e. replacement of Westaway Crèche);

[23] E.g. see WD004989/2 and WD004111
[24] EE000038/12
[25] WD005137/6
[26] WS000741
[27] EE000047
[28] EE000049
[29] WD005364/8
[30] The idea of "cottage homes" was replaced with Family Group Homes

- Function 4 – a remand home for those remanded by the courts: *"for this function a small separate building would probably be necessary"*;
- Function 5 – a reception centre to which all children would go in the first instance.[31]

3.26 As mentioned above, the young children from Westaway Crèche were moved to a wing of HDLG in February 1966. Printed letterheads from the Home indicate that HDLG was viewed as providing all-encompassing residential child care: "*Haut de la Garenne Combined Reception Centre, Remand Home and Children's Home*."[32]

3.27 In the 1968 annual report, the Children's Officer suggested that HDLG was no longer intended to provide long-term care. She noted:

> *"For children needing long-term care, and above all for large families, our four Family Group Homes provide a vital and continuing service*." [33]

3.28 A statistical analysis was compiled by the Inquiry for the 1959 to 1969 period[34] and setting out, among other things: the number of children resident at the end of each month; the number of admissions/discharges each month; the reasons for admissions; and the number of admissions by "Constable's Requests".

3.29 Over this period, the number of children resident ranged from 41 to 72. The primary reasons for their being in care and being placed at the Home were "*mother's illness*", "*social inadequacy of parents/behaviour problems*" and "*remand/condition of probation"*. The capacity envisaged for the Home in 1962 was between 60 and 66,[35] and the only month in which this number was exceeded was August 1966. By 1970, it was noted that HDLG could accommodate "*up to about 60 children of all ages until they leave school".*[36]

[31] It is unclear to what extent a reception centre was useful in Jersey in the 1960s, given that the decision was primarily between a child remaining at Haut de la Garenne and being fostered

[32] E.g. WD000188

[33] EE000064/4

[34] WD001178

[35] WD001174/4

[36] WD002619/2

Haut de la Garenne (1970–1986)

3.30 A Home Office Review carried out by Cuffe and Heady in 1970[37] provides an insight into the type and nature of establishment that Haut de la Garenne was at the beginning of the decade. It noted that boys and girls were cared for in groups; the older children had their own sitting room; a nursery wing had been built (designed for 10 small babies, although 24 children under school age were in residence). It was also noted that it was undesirable for HDLG to accommodate a group of difficult adolescents.

3.31 The Inquiry also conducted a statistical analysis of children in care at HDLG from 1970 to 1979.[38] This highlighted the wide range of children who were admitted: those who had been abandoned, those for whom a place of safety was needed, those beyond parental control and those on remand. The number of children admitted on remand varied widely – ranging from 18 in 1970 and 15 in 1973, down to 0 in 1975 and 1977. The total number of children resident at the home was generally between 48 and 58.

3.32 HDLG continued to accept children on remand until early 1979, by which time Les Chênes had opened.[39] The remand facilities were then used as "*single separation rooms*" primarily for "*more difficult older girls*".[40] HDLG ceased to be a designated remand centre in 1980.

3.33 In a July 1979 memo to the Children's Officer, Superintendent Jim Thomson identified that he saw the Home's function:

> " … *as providing facilities for short stay, intermediate and long stay care for children from 0 to 16 years. Anyone 17 years or older should not normally be accommodated here except in the most exceptional circumstances*".[41]

3.34 In 1981, Lambert and Wilkinson's inspection of HDLG highlighted that it had two primary functions, which could easily be in conflict, which was "*highly unsatisfactory*":

[37] WD002619

[38] WD002622

[39] WD002622/14

[40] Lambert and Wilkinson Report 1981, WD007382/56

[41] WD002606

- "*as the major and most accessible residential resource it provided a ready facility for a great deal of emergency and short-term care"*; and
- *"as a long-stay children's home for a substantial group of young people who have spent many years at Haut de la Garenne*".[42]

3.35 Other points identified in the inspection provide an insight into the "*type and nature"* of HDLG at that time:

- a great number of short stay children – some admitted for reasons that would not have led to residential placement on the mainland;
- ability to accommodate larger families which was "*obviously, a bonus in any service*";
- many families of children, coming in and out of care on a "*fairly regular, if not short term basis*";
- the location of the Home, in an open rural setting, five miles from St Helier, reduced opportunities for employment and recreation for older children;
- "*in professional terms the building is not suitable for any of the tasks in which it is currently engaged*".

3.36 Following the Lambert and Wilkinson report, a working party recommended a phased closure. In February 1983, the remaining children at the Home were reorganised into two groups: Dunluce and Aviemore. In 1984, children and staff in Aviemore moved to La Preference, which had recently been purchased by the States of Jersey. In December 1986, the remaining children and staff moved to the newly established Heathfield.[43]

<u>Heathfield</u>

3.37 In December 1986, Heathfield opened to provide residential care for the final children left in the Dunluce group of HDLG and was "*especially for children with behavioural problems which may have resulted from an experience of*

[42] EE000065/50

[43] WD004664

chaotic family life or similar very disturbing experiences".[44] It appears that Heathfield was, in general, used for those children regarded as "*more difficult*" but who were not involved in the criminal justice system (at which point they would go to Les Chênes). La Preference was used for children who were regarded as being easier to deal with.

3.38 There were a number of significant changes to the organisation and function of Heathfield following its foundation.[45] This included the creation of an Adolescent Community Services Team (AST), which was designed to prevent admission into residential care whenever possible by supporting children and families in the community. "Adolescents" were defined as those aged over 13 years, and the intention was to "*develop a multidisciplinary service*" to meet the needs of them and their families.[46]

3.39 It is unclear whether the whole of Heathfield was used for the AST and, if so, for how long this remained the case. In November 1989, it was noted that there were eight adolescents in residential care at the Home.[47]

3.40 In an undated "Home Statement"[48] it was noted that Heathfield had a "*dual residential and preventative function*" and that its residential care package could include:

- respite – very short but frequent breaks;
- short-term care – periods of up to three months for assessment of child situation/work with their family. If up to six months, would lead to long-term care;
- long-term care – children in care for six months or more who were unable to live at home or with relatives; which could eventually lead to semi-independent living.

[44] WD004664

[45] As part of a broader restricting of Children's Services generally

[46] WD004674/2

[47] WD004655/62

[48] WD004658

3.41 In addition to residential care, in the late 1980s and early 1990s, Heathfield operated a "shared care" facility, the aims of which were to provide a safe and supportive environment for young people to enjoy leisure pursuits, as well as to provide emotional and developmental support for young people and their parents. This involved a child arriving at Heathfield from school and staying until around 8:30pm, integrating fully with those living at the Home. Heathfield was also developing "play and family therapy" where it was considered to be in the interests of the child.[49]

3.42 In Andrew Williamson's 2008 Report on Heathfield, in contrast to the accounts we heard about the running of the Home in previous eras, he found it to be "*running well and in a calm professional manner*".[50] In his Implementation Plan, dated 2009,[51] he recommended that the Home be closed due to its being underused and its residents relocated to a smaller six-bed unit. The remaining residents moved to Brig-y-Don in June 2011. Heathfield closed in August 2011.[52]

La Preference: Private/Voluntary Home (1951–1984)

3.43 In 1951, Flora and Sidney Walden accepted three children (previously in residential care in Liverpool) into a "vegetarian guesthouse" in the parish of St Martin.[53] In 1952, the UK Vegetarian Society established La Preference as a "Vegetarian Children's Home", although, for several years, the residents were regarded as being fostered by Flora Walden.[54]

3.44 In 1954, Flora Walden had a permit to look after 14 children. However, there appear to have been 21 children in residence[55] and, by 1957, there is a note from Dr Darling of the Public Health Committee that he *"would like to cut down on the number of children at La Preference"*.[56] A letter from the Children's

[49] WD004659/36
[50] WD006408
[51] WD007433/31
[52] Day 59/126
[53] Day 54/2
[54] EE000038/8
[55] WD004109/2 and Day 54/3/15
[56] WD004109/3

Officer, dated December 1959, notes that she has "*always found a very pleasant atmosphere*" and that 12 children were in residence at that point.[57] The number of residents stayed fairly constant for the next decade, although, by 1975, 20 children were resident.[58]

3.45 We heard no evidence of any discussion at the time as to whether it was appropriate that children had a particular dietary regime simply by virtue of being placed into care.

3.46 From 1970 onwards, with the passing of the *Children (Jersey) Law 1969*, La Preference was regarded under the legislation as a "voluntary home" that had to be registered with the Education Committee and could be subject to conditions and inspections.[59] The only external inspection carried out appears to have been the one carried out by Lambert and Wilkinson in 1981, however, as noted below, the Education Committee took more of an active interest in the running of the Home from this point.

3.47 In March 1984, the Management Committee of La Preference *"concluded that they no longer wished to operate La Preference as a Children's Home and the Director had indicated that the Education Committee would be interested in purchasing the Home as a going concern"*.[60] In June 1984, the Education Committee purchased the Home, in which there were with 20 children, nine care staff and two domestic staff. The Home would continue to be called "La Preference" but would not be run on vegetarian lines from that point onwards.[61]

La Preference: States-run Home (1984–2012)

3.48 During this period, the number of residents ranged from nine in June 1985, to 14 in October 1988 and December 2002, and down to 12 in March 2004. As discussed below, Dr Kathie Bull's 2002 Report noted that La Preference was

[57] WD004134
[58] WD004115
[59] Day 54/9
[60] WD004121
[61] WD004125

often over 40% over-occupied and had an inadequate number of staff.[62] As the Home re-housed many of the children moving across from HDLG, it had to cope with "*more behavioural issues"* than before, according to Ernest Mallett.[63]

3.49 A 'Home Statement'[64] (from approximately 1999 to 2002) notes that the objectives of the Home included: *"To identify each child's physical, emotional and social needs and to work with children to arrange appropriate care experiences or programmes"* and *"to properly prepare young people for independent living".*[65]

3.50 A complaint in February 2004 about the behaviour of residents at La Preference noted that "*things have deteriorated steadily with States ownership"*, and a list of individual complaints were made.[66]

3.51 The Williamson Report: Implementation Plan, dated January 2009, noted that La Preference provided residential care for a maximum of 10 residents. It recommended that:

- up to three residents be transferred to the White House; and
- any remaining young people at Brig-y-Don be transferred to La Preference while Brig-y-Don was refurbished, and then all remaining at La Preference be transferred to the new Brig-y-Don, and that La Preference be closed and sold.

3.52 La Preference closed in October 2012, and the remaining residents (many over 16 and some over 18) were transferred to Field View, which had been renovated to provide bedsit accommodation to assist with independent

[62] WD004106/366

[63] WS000602/18

[64] This appears to have been a requirement under Part II of the Children's Home Regulations 1991, but only one has been seen by the Inquiry

[65] WD009233

[66] WD006090

living.[67] This was around two years later than the originally intended closure date of La Preference.[68]

Brig-y-Don: Private/Voluntary Home (1925–2009)

3.53 Brig-y-Don, in the Parish of St Clement, was established in 1925 as a convalescent home for children, particularly those suffering from tuberculosis. In 1932, the "Friends of Brig-y-Don Children's Convalescent and Holiday Home" was formally established as a Public Voluntary Charitable Society.[69]

3.54 The bye-laws of the Home provided that children would be accepted up to school leaving age (then 14) and would generally be short-term admissions (two weeks) unless a longer period of residence was approved by the Matron.[70] On average, most children stayed at the Home for about eight weeks.

3.55 Following the near-eradication of tuberculosis and the improved general health of Jersey's population, the Home changed. Children under 12 years of age could be admitted, if they had been "*deprived whether wholly or temporarily of their normal home life*", as could those "*in need of care and attention*".[71] It had previously been resolved that such "*deprived children"* were "*not to remain in the home for a period longer than eight weeks except in special circumstances allowed by the education committee".*[72] Up to at least 1974, there appears to have remained a general three-month limit on stays at the Home, although longer stays were necessary in special cases.[73]

3.56 In February 1970, Brig-y-Don was registered as a voluntary home under the *Children (Jersey) Law 1969*, enabling the Education Committee to arrange

[67] Day 134/132
[68] WD007433/32
[69] WD004849
[70] WD004847/6
[71] WD004847/10
[72] WD004850
[73] WD005500

inspections.[74] From this point onwards, Children's Services had an increasing role in how the Home was run.

3.57 The 1981 Lambert and Wilkinson Report[75] noted the important role that the Home played for those requiring short-term admission due to a lack of short-stay foster homes, and identified that, along with La Preference, it played a *"major part in providing a wide range of residential services for children in care"*. It was recognised that the policy of the Home was still to provide care for as short a period as possible, although noted that "*some children do become longer-term placements"*. They recorded that the Home had accommodation for 16 children, with the eldest at the time of the inspection being aged nine.

3.58 Between 1987 and 1992, the Home was involved with the policy of "*shared care*", whereby children would spend time at Brig-y-Don during the week while maintaining regular contact with their families, in order to give parents and children a break and maintain family contact.[76] From 1992, Children's Services decided to phase out this policy and to use the expertise of Brig-y-Don to provide ongoing support for foster placements.[77]

3.59 In the 1980s and 1990s, Brig-y-Don also operated an "outreach" service. This was a programme aimed at supporting families in their own homes. This service also supported children after they had left Brig-y-Don.[78] The Home offered a playgroup service and, by 1994, this had grown to accommodate 50 children.[79]

3.60 In 1996, formal changes were made to the constitution of Brig-y-Don.[80] From this point, its main objectives were to provide and maintain a Home and service for children in need; to support children in their own homes; to assist

[74] WD004854
[75] WD004830/61
[76] WD005021; WD005020
[77] WD005022 to WD005023
[78] WS000575/21
[79] WD005488/107
[80] WD005027

in the placement of children with substitute families; and to provide a day care/playgroup service to the community.

3.61 The Williamson Report: Implementation Plan, dated January 2009, noted that Brig-y-Don, which operated outside of the Children's Executive, provided residential care for a maximum of nine children,[81] who were generally of primary school age. In August 2009, the decision was taken to close Brig-y-Don as a Voluntary Residential Children's Home and the property was leased to the States of Jersey.[82] The decision was due partly to growing financial pressures and partly to the separate but related issue of the role that a large children's home could play in the provision of care in Jersey.[83]

Brig-y-Don: States-run Home (2011 to present)

3.62 Brig-y-Don was refurbished into a small unit run by the States, and re-opened in June 2011,[84] taking the young people who had previously been at Heathfield. It consisted of:

- Brig-y-Don House; a residential home for younger people aged between 10 and 16 years that could cater for up to six residents; and
- Brig-y-Don Flats; residential accommodation for young people from 10 to 16 years of age and providing a "*supported living programme*" or, in emergency situations, a package of one-to-one support for those with complex needs.[85]

3.63 Further evidence about the operation of Brig-y-Don as a recent children's home is discussed in Chapter 4 below.

Les Chênes/Greenfields

3.64 Under the *Children (Jersey) Law 1969*, the Education Committee was required to ensure adequate provision for the care and custody of young offenders. Les Chênes took over the remand role previously allocated to

[81] WD007433/28

[82] WD004841

[83] WD005036; WD005030

[84] WD004832

[85] WD008730

HDLG. It was initially intended that Les Chênes should have both teaching and care staff.[86]

3.65 Les Chênes was overseen by an Advisory Committee at the outset, and then by a Governing Body. When Les Chênes was designated as a remand centre alone in 2003 (and changed its name to Greenfields), the Governing Body was replaced by a Board of Visitors, modelled on the prison system. The Principal was answerable to the Education Committee and the Director of Education until 2003. When care staff were introduced in late 2003, the newly named Greenfields came to be overseen by the Health and Social Services Committee.

3.66 Les Chênes was never designated as a children's home: it was a residential school for children.

3.67 Most of the evidence concerning Les Chênes and its successor, Greenfields, can be dated by reference to the individuals then in charge.

1977–1988: Tom McKeon

3.68 Tom McKeon was the first Principal of Les Chênes. He told the Inquiry that his brief was "*to establish a residential school that would provide for the children who were placed on remand by the courts and who would require extended periods of residential care"*.[87]

3.69 Tom McKeon had worked at St Edwards, an approved school in the UK that did not have a secure unit. When he came to Jersey, he was given what he described as a "*blank sheet*".[88] This included the construction of a secure suite on the Les Chênes property. Tom McKeon said that it followed "*the Home Office Guidelines*" of the time.[89] The five cells that were built "*met the requirements of the day"*.

3.70 Mario Lundy joined Les Chênes as Deputy Principal shortly after the school opened. He said that there was a mistaken perception that Les Chênes was a

[86] WD004268
[87] Day 77/9
[88] WD006487/4
[89] Day 77/119

children's home, whereas in fact it was *"an approved school and remand centre for young offenders and juveniles who were out of control*".[90] We note that, according to Monique Webb, about half of the children were there on welfare placements.[91] He said that it was necessary to establish a school in the island following the abolition of approved schools in the UK and the difficulty of making placements from Jersey into community schools for education in the UK.

3.71 Tom McKeon resigned in 1988, and his post was taken by the Deputy Principal, Mario Lundy.

1986–1996: Mario Lundy

3.72 During this period, the number of children admitted to Les Chênes increased rapidly, particularly in the 1990s, following a revised admissions policy.[92] This policy allowed for a child to be admitted for long-term placement at Les Chênes "*on the imposition of a probation order with residence at Les Chênes being a condition of that order*".[93] In effect, this provision gave the court the power to sentence a child to placement at Les Chênes. The admission of children on long-term placement under a condition of a probation order undoubtedly put pressure on staff and created a tension with Les Chênes' function as an educational environment for children with behavioural difficulties.

3.73 At this time, the total capacity of Les Chênes was 20 pupils, of which four spaces were set aside for pupils from Guernsey. Staff included the Principal, Deputy Principal, two teachers, three teachers/care workers, a gardener, two domestic staff, one night supervisor and other full-time staff.

3.74 By 1991, there was pressure on the school from the court "*to provide remand facilities for 16/17-year-olds as there is inadequate provision on the island*

[90] Day 74/8

[91] Day 70/7-8 – this would be under Article 27 of the Children (Jersey) Law 1969

[92] See Day 55/32

[93] WD004214

now that the junior remand wing at the prison has been closed".[94] That proposal appears to have been abandoned:

> *"It was generally agreed that neither the prison nor Les Chênes were appropriate for such remands, but until the Young Offenders Institute reopens, the school should continue to exercise flexibility in relation to immature 16-year-olds and the Magistrates would carefully consider the use of a custodial remand in such circumstances."*[95]

3.75 In fact, some Magistrates ordered repeated remands of young people, meaning that they were, in effect, serving sentences at Les Chênes.

1996–2000: WN109

3.76 WN109 was a member of staff at Les Chênes from 1995 to 2000. For the first year, he worked as a senior member of staff under Mario Lundy. He had received training, as a teacher, in child protection, and began being in charge at Les Chênes in late 1996.

3.77 Strains relating to the type and number of remand placements, and to the approach of the courts, were already apparent in Les Chênes during this period. Examples can be seen in a letter from WN109 to Tom McKeon (in his role as Director of Education) in December 1999, recording the Magistrate's decision to remand a young person in spite of being told that Les Chênes was overcrowded,[96] and also in a letter to the Chief Probation Officer in February 2000, in which WN109 refers to the population of Les Chênes being in excess of what was intended and asks the Probation Service "*to consider alternative methods of dealing with those who breach their probation orders or are continually offending at a low level*".[97]

2000–2003: Kevin Mansell

3.78 The period over which Kevin Mansell presided was, from an organisational perspective, the most challenging in the history of Les Chênes. We consider this in more detail in Chapter 4, but, for present purposes it suffices to note that, during this period, considerable use was made of the secure cells/suite;

[94] WD006326

[95] WD006326/207

[96] WD007366

[97] WD006902

staffing levels were insufficient, leading to significant numbers of temporary staff; there was overcrowding; there were threats to Kevin Mansell and his family by a resident; prison staff were deployed on at least two occasions; there were issues with drugs being supplied by a member of staff (WN708); and, in August 2003, armed police were called to Les Chênes.

3.79 In 2001, a report to review the procedures and practices at Les Chênes was commissioned from Dr Kathie Bull. The 2001 Report[98] (discussed in more detail below) was triggered by specific events at Les Chênes in which a young person became violent toward members of staff,[99] and was critical of nearly all aspects of the school – in particular, the dual role of Les Chênes as a remand centre and a residential facility for young people with behavioural problems. Tom Mansell's evidence was that, by this time, "*welfare placements on a residential basis had pretty much ceased because of the number of people that were being remanded from court*".[100] In 2003, there was another damning report – this time by Madeleine Davies, as a result of an unannounced inspection.[101]

2003–2006: WN687 (interim)/Joe Kennedy

3.80 Les Chênes was relaunched in the second half of 2003 as Greenfields Centre. A meeting of the Governing Board in September 2003 recorded the change in responsibility of the teaching staff and the appointment of "*9/10 care staff including (WN687)"*.[102] In October 2003, the Greenfields Centre Governing Body recorded that WN687 had resigned and noted:

> "(*WN687)'s expectations of staff had been unrealistic. Currently the centre was full with ten very challenging children."*[103]

3.81 This assessment of the children as "challenging", in our view, misses the point. The function of the Home was to look after children who might well present difficulties.

[98] Review of Principles, Procedures and Practices at Les Chênes residential school, WD004270

[99] Day 80/113

[100] Day 80/36

[101] WD004276

[102] WD004031

[103] WD006312/7

3.82 Although the new Greenfields was in the same building as Les Chênes at that stage, Peter Waggot told the Inquiry that they had entirely different regimes, the former being a secure remand facility.[104] The building of a new facility to provide secure accommodation commenced straight away, and the new Greenfield Centre started operating in August 2006; as of today, the facility still operates from the same site.

3.83 Joe Kennedy told the Inquiry that, in about late 2002 or early 2003, he was approached to help with the running of Les Chênes. From 1979 to 1991, he had been a prison officer, based at La Moye; thereafter, he was responsible for training prison officers and running the Young Offenders Institute (YOI) at La Moye. He was not aware of Les Chênes throughout his time at the YOI, nor that children were held there on remand. Furthermore, he did not know that 60% of those who left Les Chênes had gone on to commit offences, for which they received custodial sentences at La Moye prison.[105]

3.84 The Governing Body minutes for October 2003 recorded that:

> "*the Director (of Education) acknowledged that he had become increasingly aware that retaining Greenfields as a school was not sustainable. It was clearly no longer an educational establishment but a remand centre. The children were very disturbed with numerous behaviour problems. Education will continue to be provided within the confines of the centre."*[106]

3.85 Joe Kennedy considered that the student population in Les Chênes and in Greenfields could properly be described as "*detainees"* because they were, he said, "*detained*". Prior to the involvement of care staff, he thought that the teaching staff had faced an "*almost impossible task of trying to merge school and home all at once*".[107]

3.86 During this period, Greenfields was required to accept admission of remanded children aged 11–16. As noted in its policies and procedures dated 2005, "*Greenfields is the designated remand centre for the Youth Court of Jersey and the purpose is to provide a high standard of secure accommodation,*

[104] Day 75/144

[105] Day 72/77

[106] WD006312/7

[107] Day 72/100

education and support for those young people for whom a remand in custody is deemed appropriate".[108]

3.87 As discussed in detail in Chapter 4, the "Grand Prix" system of behaviour management[109] was in operation during much of this period and attracted much controversy.

2006–2007: Simon Bellwood

3.88 In 2006, Simon Bellwood was appointed to run the new Greenfields. He said that, when he was interviewed for the post at Greenfields, it was made explicit to him by Joe Kennedy and Phil Dennett that the new manager should introduce the English National Minimum Care Standards.

3.89 Joe Kennedy told the Inquiry that he had expected Simon Bellwood to be much better informed "*in terms of the standards that applied*" to secure units.

3.90 In early 2007, Simon Bellwood was suspended; he never returned to Greenfields. There then followed a protracted series of formal investigation procedures and employment tribunal proceedings initiated by Simon Bellwood. The employment proceedings were settled, and the details of those proceedings are not a matter for this Inquiry.

3.91 The concerns expressed by Simon Bellwood in 2006/2007 about the management and governance of Greenfields, including the use of the "Grand Prix" system, are considered in Chapter 4. During this period, Simon Bellwood introduced a different behavioural management system.[110]

2007–2014

3.92 Following the investigations arising from Simon Bellwood's complaints, Linda Dodds and Phil Dennett concluded that there was no abusive regime and that the unit was operating well.[111] The Greenfields "Statement of Purpose and

[108] WD005767

[109] WD005763

[110] WD006710/71

[111] WD005240/74; WD006179; WD006167

Function",[112] dated April 2013, noted that Greenfields provides single accommodation for up to eight residents between the ages of 10 and 16. It can also provide accommodation for those who are disabled or who have special needs. It has an educational establishment, and all residents are expected to attend education at the specified times.

3.93 It records that admissions would usually be through either:

- the criminal justice system, or
- an application to the Royal Court by the Child Care Officer for a "*secure accommodation order*".

3.94 Joe Kennedy told the Inquiry that, as at the date of his giving evidence (June 2015), there was one occupant at Greenfields and that new policies and procedures were in the process of being drafted. As at the date of this report, it is not clear whether those are now in place.

Recent/current children's homes

3.95 The Inquiry has heard little or no primary evidence from those who have resided or worked in the following children's homes, however, as these constitute a significant proportion of the States' residential care provision in recent years, we have carried out a review of the documentary evidence held in relation to each. This is relevant both for the establishment of the "type and nature" of the Homes under Term of Reference 1, and also for our recommendations in Chapter 13.

3.96 The relevant homes are: Field View; Casa Mia; the White House; Ulvik House; and St Mark's Adolescent Centre.

3.97 The "Statements of Purpose and Function" exist for each of the homes, and the following factors are common to all:

- commitment to listening to views of residents;
- a list of fundamental rights afforded to each resident;

[112] WD008739

- promotion and protection of health;
- a description of how the home consults with residents, and facilities offered;
- the home's "Behaviour Management" policy;
- policy/procedure for reporting of abusive behaviour by staff;
- staff supervision on a regular monthly basis and annual performance review and appraisal.

3.98 The policy in respect of reporting of abuse[113] emphasised that it was the duty of all employees to report to their manager/supervisor any witnessed or suspected incidents of abuse. Employees were assured that their jobs would not be threatened by reporting the abusive behaviour of others. Any employee found to have abused a resident would face disciplinary action, which might include dismissal.

3.99 Most of the Homes also set out a common policy on control, restraint and discipline.[114] This emphasises that restraint of a resident may be undertaken only in extreme circumstances (i.e. only when other less intrusive methods had been attempted/considered) and only in extreme situations. All occasions must be recorded, and records must be made available for regular external review.

Field View

3.100 Field View opened in October 2012, following one of the recommendations of the Breckon Report in 2009[115] that:

> *"some six bedded units are provided for young people who need specialised support to provide a semi-independent living prior to leaving the care or custody system*".

3.101 Field View's "Statement of Purpose and Function", written in July 2012 (before the Home opened), notes that:

[113] E.g. WD008737/14

[114] E.g. WD008729/14

[115] WD006407/17

> "*Field View is a residential home for young people aged 16 years plus. The building can cater for up to six residents. While some residents may be care leavers, others may never have had any prior experience of residential care."*[116]

3.102 As regards the Home's aims and objectives, it notes:

> "*we aim to provide a need led service which treats all young people as individuals. The objective is to work with young people to empower and support them to move into their own accommodation, when they have the confidence and skills to do so".*

3.103 The Home provided services for those in care, those who had just left care and those who had never been in care but were deemed to be "in need" or for whom such a placement would "safeguard or promote" their welfare.[117]

3.104 There would generally be one or two care staff on shift (with six residents) and the "Statement of Purpose and Function" set out that daily risk assessments would be carried out to ensure that sufficient staff were available to adequately deal with the needs of residents. Each resident would have a support worker with responsibility for the "*most important aspects"* of their care. The relevant qualifications and experience of 10 care staff are set out,[118] from which the following can be noted: that all had done child protection courses, all were trained in therapeutic crisis intervention (TCI), and almost all had at least an NVQ Level 3 in Health and Social Care/Care of Children and Young People.

3.105 The Board of Visitors' Annual Report from October 2013 noted[119] that staff numbers had remained the same as in La Preference, but, due to the age of the residents and the independent living plan, it had been suggested that the number of staff would reduce in the future. The 2014 Report of the IVYP,[120] the new incarnation of the Board of Visitors, found that all the original residents had moved on, and that the ethos was very different to that at La Preference, which had more of a "family feel", but this was likely to be due to the increased independence of the young people. No issues had been raised

[116] WD008737

[117] Article 17, Children (Jersey) Law 2002

[118] WD008737/9-12

[119] WD009019/10

[120] WD009325/11

by residents, although the IVYP were finding it difficult actually to meet with them because they were usually out.

Ulvik House/Casa Mia

3.106 Ulvik House opened as a children's home in March 2011.[121] The property was rented on a short-term lease and, as at 2012, two young people with specific needs lived there.[122] When the lease expired in September 2012, the residents and staff moved to Casa Mia, in the Parish of St Lawrence.[123]

3.107 The "Statement of Purpose and Function" document for Casa Mia, approved in May 2013, states:

> "*Casa Mia is a residential home for young people from the age of ten. Casa Mia can cater for up to 3 residents. The home was set up specifically for young people requiring a higher level of intense support and nurturing*."[124]

3.108 The age range for admission is 11–16 years[125], and the reports note that the residents are able to stay until 18 years of age.[126] The "Statement and Purpose" notes that there should generally be two care staff on shift, although, at night, one would be sleeping and one waking. The relevant qualifications and experience of seven care staff is set out,[127] from which the following can be noted: that all have done some child protection training, TCI and general systems theory (GST), and all have at least six years' experience of working with children and young people, with some having far more.

3.109 An undated "Young Person's Guide" shows the information provided to residents upon arrival at the Home. It notes some of the potential consequences for misbehaviour, such as grounding, extra chores and "*temporary separation from other young people*". It also highlights some of the things that staff would not do, including *"hitting you; depriving you of food or*

[121] EE000080

[122] Children's Policy Group report, WD007059/10

[123] WD009365/8

[124] WD008748

[125] WD009225/2

[126] WD009019/9

[127] WD008748/10

drink, restricting visits; punishing a group for the acts or omissions of a single person".

3.110 Children are admitted to the Home by the Placement Panel,[128] following an application by the allocated social worker, and various assessments of the child's suitability for the Home. No emergency admissions are accepted.[129]

3.111 The Board of Visitors' Annual Report dated October 2013 noted that the dynamic of the Home changed when the family bedroom "*originally intended as a study*" was used for emergency placements. One resident said "*it is now not viewed as a home, a tight unit, but as a care house where everyone is now expected to make room for another person*". The Board of Visitors concluded that "*whilst it is important to accommodate vulnerable children, the tenets on which each Home was founded should not be disregarded in the way they appear to have been in this instance".*

3.112 In relation to this Report, Phil Dennett explained in evidence[130] that one of the problems Jersey faced as a small jurisdiction was placement for emergency cases. He told the Inquiry: "*our philosophy was ensuring minimum disruption to the young people already in residential care, but what we do not have the luxury of here is going further out of town, to the next authority, looking for a placement".*

3.113 A six-monthly report of the IVYP was completed in April 2014.[131] It noted that the Home had become more settled, the number of residents had been only temporarily increased to four and there was increased continuity of staff members.

<u>The White House</u>

3.114 The White House opened for specialist residential purposes in 2009, on the refurbished site of the Headmaster's House at the old Les Chênes.[132] A file note from the Law Officers' Department, after a visit to the White House in

[128] This was established in 1999 to decide where to place children in care

[129] WD008748/6

[130] Day 134/130/17

[131] WD009310/4

[132] EE000038/16

June 2009, noted that the Home was used to provide intensive care to two children. It was very expensive due to the requirements of 24-hour care.[133]

3.115 In evidence to the Inquiry, Phil Dennett described his vision for the White House as being:

> *"trying to have some flexibility in the staff group that we would keep the White House as a response where we could house very quickly young people who needed to come into residential care on an emergency basis and with staff that we could call on to man that home for a short period of time whilst we considered the longer term vision and we had actually created that ability because the White House, the young people who had been there had moved on and we on paper kind of closed that unit, but it was in a vision to kind of mothball it so it was available for these kind of emergency situations. It was not available when this situation arose at Casa Mia".*

3.116 The "Statement of Purpose and Function", approved in July 2012, states: *"The White House is a residential home specialising in therapeutic care for two young people"* and notes that it *"provides therapeutic parenting to young people traumatised by their life journey to date".*[134]

3.117 Staffing ratios were generally supposed to be 1:1, and the relevant qualifications and experience of seven care staff are set out,[135] from which it can be noted that all have done some child protection training, TCI and GST. There is no reference to the level of experience of the team of staff, in contrast with the documents on Field View and Casa Mia.

3.118 The Board of Visitors' July 2012 quarterly report described the White House as "*the home situation to which all the other Homes should aspire"*, noting that there were excellent relationships between residents and staff, the Home was well run and was a happy place to visit.[136]

[133] WD007354

[134] WD008749/5

[135] WD008749/10

[136] WD009237

3.119 The Home was closed in April 2013 due to relocation of residents – something that the staff felt was due to "*financial dictates*".[137] It re-opened in 2014, when three young people were admitted.[138]

3.120 In July 2015, a serious case review was published about events at the White House two years previously, involving a young person being admitted to the Home and therefore becoming a "looked after" child.[139] The Review noted, when looking at the assessment and management of risk, that the focus of the staff at the White House, in that one specific case, had been one of "*containment*". The only treatment that was offered was through medication, which was regularly reviewed. There was "*no structure or plan to the days and psychological therapies were not offered in a systematic way".*

3.121 The Home provides accommodation in single rooms for young people within the age range 10–16+ years.[140] The admission procedure is as described for Casa Mia.

3.122 The 2014 Annual Report by the IVYP noted that, upon the re-opening of the Home at the beginning of the year, there had been a reliance on staff from other Homes or on bank staff, which meant that there was a lack of continuity for the residents and the staff themselves. However, the situation was eventually remedied with the appointment of more permanent staff. They noted that the Home continued to provide a homely atmosphere for the young people, with staff working hard to try to prevent challenging situations from escalating. The Report also recorded admiration for the speed and professionalism of the response by so many staff following the tragedies involving young people at Christmas.

Other facilities

Seaview Flat

3.123 A facility used, as of October 2014, when foster placements have failed.[141]

[137] WD009019/15

[138] WD009325/13

[139] The events dealt with in the report fall within the timeframe with which the Inquiry is concerned

[140] WD007356/3

Homeless Young Persons' Project (HYPP)

3.124 HYPP opened in October 1989, as a joint venture between the Children's Department and the Youth Service, to provide accommodation for eight homeless young people aged 16+ years.[142] By 1995, it was accommodating 10 young homeless people in the 16-20 age range.[143] Situated on St Mark's Road and commonly known as "St Mark's",[144] it was described by Tony Le Sueur as having had "*minimal staffing*"[145] and, as at 1994, it is recorded that residents did not normally have a child care officer ("CCO").[146]

St Mark's Adolescent Centre

3.125 HYPP evolved into the St Mark's Adolescent Centre in 2000, providing accommodation for the homeless aged over 16 years, or those who arrived in Jersey with no viable means of financial support. All staff working in St Mark's were residential CCOs,[147] and a policy document from 2006 shows that staff were required to be trained in "De-escalation and break away techniques", but not in TCI. Although it appears that some young people were resident at St Mark's who were not in residential care, it is clear that, in 2006, it was regarded as the responsibility of the Children's Service,[148] and Joe Kennedy gave evidence that, at that point, he was involved in the management of Heathfield, St Mark's and La Preference.[149] In 2012, it was described as providing accommodation for 11- to 18-year-olds to prepare them for independent living. In 2013, the building being "*no longer fit for purpose*", most residents were relocated to Strathmore.[150]

[141] WD009325/8
[142] Recommended by Lambert and Wilkinson Report; EE000038/12
[143] WD006276
[144] E.g. see WD006276
[145] Day 4/101
[146] WD004672
[147] WD004832
[148] WD008738/8
[149] WS000581
[150] WD009019/13

Strathmore

3.126 Strathmore is a hostel providing high-support, medium-term accommodation for 21 vulnerable young people aged between 16 and 25 years old. The hostel has 18 rooms. Most residents are working young people, many of whom have come through the care system, and "*once they have the skills to support themselves they can move into one of these homes and take up a more traditional bedsit arrangement, pay their rent and then they will be considered to go into the private sector*".[151] In advice provided by the Law Officers' Department in July 2013, it was noted that any resident under the age of 18 who is accommodated for longer than 24 hours would be considered a "looked after child" under the *Children (Jersey) Law 2002*.[152]

Aviemore

3.127 The former Westaway Wing of Haut de la Garenne was converted to provide residential respite care for children with special needs. Although we have no evidence as to exactly when, at some point the unit was renamed "Aviemore". In 2004, the two self-contained flats transferred to the newly established "Lifelong Special Needs Service" and the flats were used for two adults. As discussed below, this unit was the subject of allegations of physical and sexual abuse in the 1990s and 2000s.

Eden House

3.128 Eden House opened in June 2009, to take over the short-break service for children and young people on the autistic spectrum that had previously been provided by Aviemore.[153]

3.129 Despite this original intention, it became a *"permanent home base for a couple of young people who could not live permanently with their family, with severe challenging behaviour around their autism and special needs",*[154] and the "Action for Children Report" in 2012 noted:

[151] Day 4/113, Tony Le Sueur

[152] WD009379

[153] WS000618/26

[154] Day 134/133/4

> "*It is well documented that the unit has suffered from having to spread its resources across a very wide remit that includes shared care arrangements and long-term emergency arrangements. This has disrupted the respite arrangements and caused additional concern and pressures for children, families and staff."* [155]

3.130 In March 2015, Dr Catherine Howden (Medical Adviser for Looked After Children) noted that only respite for younger children was carried out at Eden House, due to the lack of space.[156]

Oakwell

3.131 In September 1986, Oakwell was developed in the Parish of St Brelade as a specialist children's home for physically handicapped children. It offered permanent residential care for three children, with a fourth bed for respite care, and although operated by the Special Education Needs Sub-Committee of the Education Committee, according to Tony Le Sueur: "*there was an acknowledged interest in the home on the part of the Children's Sub-Committee".* Over the years, this developed as a specialist unit for those with multiple and/or profound health and social needs. It was managed by the Life-long Special Needs Service from 2004 and then moved to the Children's Services directorate in 2011.[157] A report from July 2009 by Ann Kelly, Lead Nurse for Children, concluded that Oakwell provided an "*invaluable service for vulnerable children and their families"*, however, there were some concerns about governance, lack of security and the lack of a clear vision for the future.[158] In the 2012 "Action for Children" report,[159] it was noted that Oakwell accommodated up to four children or young people with profound or multiple disabilities or severe mobility problems.

Family Group Homes

3.132 The proposal to establish Family Group Homes (FGHs) on the island was put forward by the Director of Education in 1958 and was agreed by the

[155] EE000082/8

[156] WD009327/2

[157] EE000038/12/16

[158] WD009361/26

[159] EE000082

Education Committee in 1959.[160] As noted below, in Jersey, there were five FGHs in all, and the first one opened in 1960. FGHs had been set up in England in the 1950s, originally as Cottage Homes.

3.133 The concept was to provide children in residential care with as normal a home and family life as possible, by placing them in a Home no larger than one for a large family, with a couple in charge acting jointly as Houseparents. The idea was that, in this way, siblings could grow up together in a less institutionalised setting. The concept was abandoned in the UK in the early 1980s, and the final FGH in Jersey (Blanche Pierre) was closed in 1993.

Nicholson Park/Clos de Roncier

3.134 46 Nicholson Park, in the Parish of St Saviour, was the first FGH and was ready for occupation by September 1960. It catered for a small number of children ranging in age from nine months to 14 years,[161] and the Houseparents were Mr and Mrs Edwards. In March 1965, they moved with the residents to a new property at Clos de Roncier, which coincided with an increase in the number of residents.[162] The Home closed in June 1977, following the sudden death of Mrs Edwards, at which point Mr Edwards was given notice to quit. The residents were re-distributed across the other States' facilities.[163]

Clos des Sables

3.135 Clos des Sables opened as a FGH in September 1964, in the Parish of St Brelade, and provided accommodation for up to eight children.[164] The Housemother, Janet Hughes, was employed by the Education Committee to run the Home and be the primary carer. The Housefather, Leslie Hughes, was given "*full keep*" in exchange for his share of responsibility in running the Home. He was expected to "*follow his own employment*".[165] Although he was

[160] WD005364; WD004999
[161] EE000052/2
[162] WD004991
[163] EE000038; WD004998
[164] WD007382/62
[165] WD000166

not an employee of the Education Committee, he was responsible for children who were in the care of the States.

3.136 The Lambert and Wilkinson 1981 Report noted that "*accommodation at the home is extremely limited*". At the time of the inspection, fewer than eight children were in residence, and most were teenagers and female.

3.137 Mr and Mrs Hughes left Clos des Sables in March 1989, following allegations of sexual abuse made against Mr Hughes. He was arrested and, in October 1989, was convicted on five counts of sexual assault against three girls who had been in care at Clos des Sables.[166]

3.138 Audrey Mills took over the management of the Home before it closed at the end of 1989. The remaining residents moved on to various other homes.

Family Group Home run by WN279 and WN281

3.139 This FGH opened in May 1967,[167] and the Houseparents WN279 and WN281 lodged their first report with the Children's Sub-Committee in December 1967.[168] The children at the Home were two sets of siblings and one individual child. One of the sets of siblings was chosen by WN279 and WN281 after they had met them at HDLG along with another family.[169]

3.140 In December 1968, new premises were leased by the States[170] and the children and Houseparents moved in around June 1969[171] to another address. The FGH closed in 1977, following the retirement of WN279 and WN281.

Norcott Villa

3.141 In September 1968, the Education Committee agreed to rent a property in the Parish of St Saviour.[172] Houseparents WN791 and WN585 moved in by July

[166] WD000165
[167] WD001388
[168] WS001390
[169] WS000713
[170] WD001392
[171] WD001394
[172] WD005048

1969, with two part-time Assistant Housemothers and a group of children. Norcott Villa initially housed children from three different families.[173]

3.142 Although the Housemother, WN791, had her appointment confirmed after completing a probationary period in March 1970,[174] her employment was terminated two years later "*following adverse reports affecting the care and control of the children and adolescents*".[175] The Inquiry has not seen any evidence as to the origin of these adverse reports, nor whether they related to any allegations of mistreatment or simply a lack of control.

3.143 WN331 and WN332 applied for the role of Houseparents and were offered the job in April 1972. A report from July 1976 suggests that, between October 1975 and February 1976, 10 children were in care at Norcott Villa.[176]

3.144 In November 1976, the Children's Sub-Committee recommended the closure of Norcott Villa. In September 1977, the Houseparents and some of the children moved to a vacant property on the Le Squez estate.[177]

3.145 The Houseparents separated in December 1979, and WN332 remained in post until April 1980. The Education Committee set out its recommendations for recruiting replacement Houseparents and noted that:

> "*Following the appointment of the new Houseparents, the word 'Family' be deleted and the establishment be seen as a Group Home, enabling the maximum children accommodated to be increased to 10*."[178]

3.146 This change in wording resonates with the evidence given by Houseparents of other FGHs, such as Janet Hughes, about the gradual evolution of the FGHs into small children's homes.[179]

3.147 In April 1980, WN332 moved to HDLG and the "Group Home" on the Le Squez estate was taken over by Jane and Alan Maguire. Jane Maguire previously worked as a residential carer at HDLG.

[173] EE000038/11
[174] WD002050
[175] WD006970
[176] WD001406/67
[177] WD005051
[178] WD005060
[179] Day 69/67

Blanche Pierre (Le Squez Estate)

3.148 As discussed above, in April 1980, Jane and Alan Maguire were appointed Houseparents of the Group Home on the Le Squez estate, which we refer to as "Blanche Pierre" (as it became more commonly known during the Police investigations in the 1990s).

3.149 Mr and Mrs Maguire ran Blanche Pierre, in which a number of sibling groups were resident, until 1990, when allegations were made by two staff members that Mr and Mrs Maguire had been mistreating the children in their care. These allegations, and the response to them, are dealt with in considerable detail in Chapter 9. The running of Blanche Pierre was taken over by Audrey Mills until 1993, when some of the children returned to their parents and some were fostered by Audrey Mills.

Fostering services

3.150 In this section, we set out, in some detail, the type and nature of fostering services over the relevant period, including: its role within the wider provision of children's services; recent policies, procedures and guidance; and the evidence of foster parents themselves about how fostering operated in practice. We are not required by the Terms of Reference to make any findings under this section (as to the type and nature of the services), however, we do make findings on the oversight of fostering services in Chapter 5.

Background

3.151 As set out above, fostering services have included the placement of children privately from one family to another (sometimes called "private fostering") and the placement by the States of Jersey of children in their care with approved foster parents (sometimes called "boarding out").[180] The term "foster child" is used throughout the evidence to refer to either type of placement.

3.152 In Tony Le Sueur's report to the Inquiry,[181] he referred to some of the issues that arose specifically in relation to fostering in Jersey:

[180] Day 60/103

[181] EE000038

- limited social welfare services;
- restricted housing stock and restrictive housing laws;
- large number of itinerant workers;
- factors particular to the Occupation, including children being sent to the UK; managing the return to the island for those who had left; and children born during the Occupation and regarded as "illegitimate" at that time.

3.153 For context, we note the following finding from the 1946 Curtis Report, reviewing child care provision in the UK: *"On the whole our judgment is that there is probably a greater risk of unhappiness in a foster home but that a happy foster home is happier than life as generally lived in a large community."*[182] The *Public Instruction Committee Act 1949* confirmed the boarding out of children wherever possible as a definite policy.

1945–1959

3.154 The Public Health Committee had responsibility during this period for the supervision of private fostering arrangements and the placement and supervision of children boarded out.[183] The *Public Instruction Committee Act 1954* provided that any application for a child to be received into care would be made by the Connétable or the person responsible for the maintenance of the child. The Act gave the Committee the discretion to admit such children to a children's home or to board them in a private home.[184]

3.155 Following the Act becoming law, the Medical Officer of Health expressed concern about the multiplicity of controls between the Public Health Committee, the Connétable and the Poor Law Commission relating to "*children boarded out or otherwise under the care of the States".* On

[182] EE000096/68

[183] Under the 1940 Loi: GD000002

[184] LG000181

occasions, this resulted in different agencies making conflicting decisions about the suitability of a prospective foster mother.[185]

3.156 Reports from the 1950s record attempts to place a greater number of children in care with foster parents, recognising that it was a better solution than any institution.[186] In 1951, a report by Ms Gracey of the Public Health Committee noted that there were 35 foster mothers caring for 54 children.

3.157 Although, in Jersey, there was no equivalent of the *Boarding Out Regulations 1955* (until 1970) and therefore no legislative requirements stipulating the frequency of visits, reports etc, boarded-out children were visited by officials such as the Health Visitor, and foster parents had to have permits issued by the Public Health Committee.[187] On the basis of the files reviewed, it is unclear to what extent guidelines were in use about visiting children or granting/revoking permits for foster parents.

3.158 The 1955 Annual Report to the Education Committee noted that there were 41 children boarded out privately, 56 boarded out by the Parishes, seven boarded out by the Education Committee and one transferred from England. They stated that "*new foster homes are urgently required"* and went on to note that:

> "*Under the present law, a child attaining the age of fourteen years ceases to be a foster child. The problems of some of these adolescents are still much in evidence and provision for help and advice are very necessary. The advantages of placing children in suitable foster homes are not fulfilled unless adequate supervision is available where it is needed between the ages of fourteen and eighteen years*."[188]

1959–1969

3.159 The year 1959 saw the appointment of Jersey's first Children's Officer, Patricia Thornton – 11 years after similar appointments had been made in England. Annual reports were published,[189] which included statistics about the number and proportion of children in care who were in foster homes, and the

[185] EE000157

[186] EE000153

[187] WD004603

[188] WD008743

[189] E.g. EE000052/3; WD004577; WD004578; WD004579

increasing numbers suggest that Patricia Thornton encouraged the boarding out of children. It is noteworthy that, by the end of 1961, 59% of children were in foster homes, although a proportion of them were privately placed, and this number dropped over the next couple of years.

3.160 Despite there being no legislative regulation governing the boarding out of children during this period, the Public Health Committee appears to have considered applications under the *1940 Loi* designed for private fostering.[190] There appears to have been a system for the approval of foster mothers, including applications by the Children's Officer, the inspection of the home, the obtaining of certificates, the consideration of an application by the Public Health Committee and the issuing of permits by the Deputy Greffier of the States.[191]

3.161 A 1965 Home Office Inspection of children's services in Jersey spoke positively about the supervision of boarded-out and privately fostered children, noting that the breakdown of placements was very rare.[192] By 1968, there were 150 registered foster parents on the island who held permits under the *1940 Loi*.[193] The Medical Officer of Health requested Ms Thornton to check and update the list every three months, although it is unclear whether this in fact happened.[194]

3.162 Foster parents caring for "difficult" children who needed special attention received supplementary payments from 1968.[195]

1969–1981

3.163 In 1969, the *Children (Jersey) Law* was passed. The Law crystallised the duty of the Education Committee in relation to all children in care to *"exercise its powers with respect to [the child] so as to further his best interests and to afford him opportunity for the proper development of his character and*

[190] WD002448/6
[191] WD002448
[192] WD006689
[193] Loi sur la Protection de l'Enfance
[194] WD004619
[195] WD004625

abilities". The Committee was required to give primary consideration to boarding out a child received into care and only to place a child in a Home where boarding out was not practicable or desirable.[196] Furthermore, the regulation of private fostering arrangements was tightened.[197] As was provided for in the *1969 Law*, the *Children (Boarding Out) (Jersey) Order 1970* was subsequently passed to regulate the boarding out of children.

3.164 David Castledine noted that, during the 1970s (when he was a CCO), the assessment and registration of foster parents was not as thorough, although an application still had to be made, references would be taken, and accommodation would be checked.[198] He said that the provisions of the *1970 Boarding Out Order* were not always followed. He spoke to Charles Smith, the Children's Officer, about his concerns. However, Mr Smith thought that the constraints of manpower made adherence difficult.[199]

3.165 In 1970, Lucy Faithfull (Oxford's Children's Officer)[200] visited the Children's Department in Jersey and commented that she was impressed by the quality of foster parents but thought that the boarding-out allowances should be increased:

> "*Whether with the rising cost of living you would not consider that the boarding out allowances are somewhat low. Should foster parents fail to offer a service it would be necessary to set up more residential accommodation for children which is extremely expensive although very necessary for some children.*"[201]

3.166 Evidence about the adequacy of allowances and attempts made to recruit foster parents runs through various reports. There appear to have been regular reviews in the 1970s of allowances in Jersey in comparison with those paid by local authorities on the mainland; there are examples of increases in the rates in 1975, 1977 and 1979.[202]

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[196] Articles 89-90; EG000032/51–52

[197] Articles 55–64

[198] Day 85/22

[199] Day 85/82

[200] Later Baroness Faithfull, Chair, All Party Parliamentary Group for Children

[201] WD004624

[202] WD004613; WD004612; WD004609

3.167 In 1979, the Education Department voiced concerns about "illegal" private fostering, i.e. those engaged in private fostering arrangements but not registered with the Education Department. The Children's Officer Charles Smith, is recorded as commenting at the time that the Children's Department had a "*minimal role to play*" in private fostering and that they simply had to ensure that "*physical standards*" were satisfactory, with "*none of the stringent procedures*" required for those boarded out.[203] In fact, there was an explicit duty, under *Article 57 of the 1969 Law*, "*to satisfy themselves as to the well-being of the children*" and not simply ensure that the "*physical standards*" were satisfactory.

3.168 Professional fostering was first advocated by Charles Smith (Children's Officer) in 1977. The concept was that foster parents would be trained to care for so-called "*disturbed, delinquent and handicapped*" children and recruited at a higher rate of pay.[204]

3.169 The proposal was raised again at various stages, but, as at April 2014, it had not been launched. Evidence suggests that, during the 2000s, a scheme was implemented whereby enhanced allowances were offered for the placement of young people regarded as "*difficult to place*", as distinct from professional fostering whereby skilled and experienced individuals are paid to be full-time foster parents. There were further attempts from 2011 onwards to develop a "*specialist fostering service*".[205]

1981–2002

3.170 The 1981 Lambert and Wilkinson Report made a number of comments about fostering in Jersey.[206] They concluded that professional fostering would "*flounder before it is off the ground through lack of basic groundwork and adequate staff*".[207] They also noted that *"the unique housing problems of the island mean the potential foster parents often do not have a spare bed let alone a spare room for a foster child*" .Specific reference is made to issues in

[203] WD004611

[204] WD002185; WD004593

[205] See section on 2002–2014

[206] WD007382

[207] WD007382/32

respect of recruitment and training of foster parents, and criticisms are made of the standard of record keeping and lack of senior reviews. However, the department's guidelines (not seen by the Inquiry), indicating bi-monthly visits for long-standing cases, were followed in most cases.

3.171 Two key recommendations were made; first, for the appointment of a dedicated Fostering Officer, which was implemented in 1982; and, secondly, for a policy setting out fostering as the primary method of substitute care for children. It is noted that this policy was contained within the *1969 Law* (and in a previous Act of the Public Instruction Committee) and therefore it is perhaps of no surprise that no specific policy appears to have been articulated.

3.172 In 1982, David Castledine was appointed as Fostering Officer (or Child Care Officer (Fostering)) and remained in post until approximately 1993. In evidence to the Inquiry, he said that he was concerned that the fostering systems were incoherent and therefore began to establish a more organised process. On appointment, he remained as a CCO with a huge caseload and no teams to support him.[208]

3.173 David Castledine's first annual report to the Children's Sub-Committee in 1983[209] noted the implementation of an assessment programme for potential foster parents, as well as other support for foster parents. David Castledine noted in his statement to the Inquiry that he began using British Association for Adoption and Fostering (BAAF) precedents to establish formal structures in the assessment process and also implemented a requirement that each applicant undertook training over a three-month period before registration. Once registered, they would be offered continual training programmes that were non-compulsory.[210] His annual report in 1987[211] made the following points:

- He thought that there were three categories of children whom it was difficult to place:

[208] WS000609
[209] WD004705
[210] WS000609
[211] WD004587

1. those with special needs – for example, emotionally disturbed children;

2. children in a large families (three or more); and

3. teenagers who *"appear to be the least attractive fostering prospects and the group with the highest ratio of breakdown".*

- Training was: *"a subject I view as a priority … a group of trained foster parents would widen the scope that is necessary for those difficult to place"*.

- There was a need for *"available families"* able to offer to accept, in an emergency at any time of the day or night, those children with problems.

3.174 In 1988, a major fostering campaign was launched and, while there was a "*fairly good response*", the Children's Sub-Committee go on to say:

> "*however, it is also noticeable, as in the past, that the response of the Jersey community to fostering appeals is fairly muted compared with … a mainland area".*[212]

3.175 In evidence to the Inquiry, David Castledine said that, during his time as Fostering Officer (1982–1992/93), a Fostering Panel would not have been possible due to the lack of manpower.[213] He also said that CCOs would regularly visit children in foster care and any suggestion of abuse would be met with increased contact; that there was ongoing supervision of foster parents when a child was placed; and that he brought in a process for deregistration of foster parents. Examples of deregistration, which subsequently became the role of the Fostering Panel, can be seen in Chapter 9 below, in relation to allegations of abuse. However, we also note a 2007 example of a foster mother being de-registered following a number of complaints about her ability to communicate, her lack of insight and the risk related to her providing foster care for vulnerable children. This was initially recommended by the supervising social worker, then by the Fostering Panel,

[212] WD004589

[213] Day 85/89

and then finally decided upon by Tony Le Sueur as "Agency Decision Maker".[214]

3.176 In August 1999, an "Adolescent Fostering Research Project" report[215] made the following findings and recommendations:

- current resources for adolescents did not meet their needs, and the Home Finding Team was under resourced;
- placement of an adolescent (those aged over 12 years) would be sanctioned only after a six-week assessment at Heathfield;
- a CCO should be appointed as a Training Officer for all foster parents, increasing support available to foster carers, including the provision of "*complete information*" at the time of placement;
- the lack of a Fostering Panel was contrary to good practice in the UK and in Guernsey. The Report recommended that a panel be established to determine the suitability of a foster carer and the number/age range of children for which they were to be approved;
- communication with foster carers, young people in care and others needed improving;
- closer supervision of link workers and CCOs regarding their communication with foster carers;
- a Placement Panel be created to ensure that all children in care were appropriately placed and monitored;
- "*independence training*" to begin at 15 years of age, along with supported lodgings to those over 16 who wanted to live semi-independently.

[214] WD008575

[215] WD009208

2002–2014

3.177 This period began with Dr Kathie Bull's 2002 Report, which identified the advantages of placing children in foster care and the urgent need for increased investment, including the development of professional fostering and the introduction of treatment foster care programmes. The Health and Social Services Committee noted, in the same year, that " … *increased investment would be required to achieve the provision of similar levels of long term fostering to the United Kingdom*".[216] The total cost of a new professional foster care service (based on the UK model) was estimated at £402,000 per year.[217]

3.178 Tony Le Sueur became Team Manager of "Fostering and Adoption and Children in Care" in February 2002, having previously been responsible for the services under the aegis of the Homefinding Team since October 1999. He gave evidence to the Inquiry[218] and described an element of "*disbelief*" that Dr Kathie Bull's proposals on fostering were not implemented. He said that attempts to secure additional funding for fostering were unsuccessful due to a lack of political will. He also highlighted some of the reasons for the lack of available foster care, including *"limited and very expensive accommodation in the island*" and "*the very high cost of living*", which inevitably caused both partners in a relationship to have to work. In oral evidence, he noted that Jersey was one of the few places not to require one of the foster parents to be at home and that they had also tried to offer enhanced rates.[219] He made various recommendations to overcome the problems with fostering, including assistance from the Housing Authority and the reform of tax arrangements to assist families who take on fostering.

3.179 The *Children (Jersey) Law 2002* introduced comprehensive legislative changes, including detailed provision on private fostering. The legislation did not come into force until 2005[220], at the same time as new Boarding Out

[216] WD004600

[217] WD004601

[218] Day 90; WS000619

[219] Day 5/26–29

[220] See Richard Whitehead's expert evidence: EE000261/38

Regulations. By this time, a Fostering Panel was in place[221] that was responsible for registration and de-registration of foster parents and reviewing placements for children.

3.180 Andrew Williamson's 2008 Report, "Inquiry into Child Protection in Jersey",[222] noted that the success of the programme to recruit more foster carers and adoptive parents had led to a significant reduction in bed occupancy at Heathfield and La Preference. We also note the explanation of the function of the Fostering and Adoption/Permanence Panels in place as at January 2009, which can be found in an appendix to the Williamson Implementation Plan.[223]

3.181 The Scrutiny Panel's report[224] (the "Breckon Report") into the "*Co-ordination of services for vulnerable children*" in July 2009 made the following findings/recommendations, with the assistance of reports by Professor Ian Sinclair:

- Of 32 looked after children of primary school age, 78% were in family placements (17 with foster carers, six with kinship foster carers and one home on trial) and eight in residential care.

- There was an age group (over-10s) who may have been better suited to the lifestyle of a children's home rather than a foster home (this was a view shared by the Jersey Care Leavers' Association and by Professor Ian Sinclair). The reasoning was that this age group may have felt that they would always be an outsider in the family, or that they had their own family and it would be disloyal to commit to another family, or that they had had enough of families.

- For those younger children for whom foster parents could not be found, Brig-y-Don was a suitable interim preparatory step to successful fostering. This was notwithstanding Professor Ian Sinclair's view that *"long-term residential care for young children should now be avoided*".

[221] Tony Le Sueur thought that this was set up in 2001

[222] WD006408

[223] WD007433/70–74

[224] WD006407/100

- That Jersey should spend more on developing new and innovative types of fostering: for example, respite fostering where foster carers are twinned with a family.

3.182 The Ministerial Response, provided in October 2009, included the following statement when pointing out that local allowances were in excess of London rates: "*The Minister is aware that foster carers who are prepared to make a place for needy children in their homes and in their lives, do so for reasons beyond money*."[225] It also noted that formal administrative procedures for facilitating the development of the "complex arrangements" around professional fostering were being pursued, although, as before, this does not appear to have yielded any substantive provision.

3.183 Phil Dennett (Chief Executive Co-ordinator in 2004; Director of Children's Services 2011 to 2014) told the Inquiry that investment was put into fostering in Jersey, but that there were difficulties. In his view, "*the social profile of people who might foster did not exist in Jersey*". He explained that the high cost of renting excluded people who might otherwise foster, as did the inability of people to afford a spare room. Foster carers were not paid, although attempts were made to enhance their allowance. He considered that the problem with fostering in Jersey lay with the States as a whole rather than with the fostering team, who did the best that they could. He believed that, by 2014, fostering services were in a good state and there was a fostering and adoption team of around 111 people to help recruitment, as well as providing support and training for foster parents.[226]

3.184 A 2011 Report by Sean Pontin (Head of Children's Social Work), entitled "Specialist Foster Care in Jersey", noted:

- "Fostering and Adoption Jersey" (previously the Homefinding Team) had a dedicated role in recruiting, assessing and supporting foster carers, kinship carers and adopters;

[225] WD009134

[226] WS000628 and Day 95/80–82

- the number of approved foster carers was 35. Over 90% of all primary-school-age looked after children were cared for in family placements;
- the service could not attract carers prepared to look after or capable of looking after children with more demanding or challenging behaviour and/or teenagers. They therefore made up the population of residential homes or required specific placements in the UK;
- a "specialist fostering service" was required to attract new people to fostering – tapping into other sections of the community. This service would offer higher levels of support, training and remuneration than standard forms of foster care, and individuals would be specifically recruited and intensively supported.

3.185 The January 2012 "Inspection of Services for Looked After Children" by the Scottish Care Inspectorate noted the following about fostering services:

- *"Impact on employees and foster carers*" and the "*management and support of employees and foster carers"* were rated as "*weak*" (however, no specific recommendations were made with regards to foster carers);
- although the proportion of children looked after in family placements had increased steadily, the target of 80% by 2010 had not been met;
- the experience of the majority of looked after children and young people living with foster carers was very positive;
- there had been no progress in the development of professional foster care;
- budget pressures prevented recruitment to the "Intensive Support Team", which was designed partly to provide support to children, young people and foster carers to prevent foster breakdown.

3.186 A further report by Mr Pontin in July 2012[227] set out the key elements of a specialist foster care service and the benefits of such a scheme. Jersey had the highest percentage of working parents in Europe, which, as Mr Pontin

[227] WD009153

noted, presented specific challenges to recruitment. A service specification was drawn up in January 2013.[228]

Evidence of foster parents

3.187 The Inquiry received evidence from various foster parents. This provided us with an insight into their perspectives on fostering services, as well as an insight as to how systems actually operated in practice.

3.188 Those witnesses were:

- Nancy Elson[229]
- WN480 and WN481[230]
- WN264[231]
- WN665 and WN666[232]
- Foster father of WN241[233]
- WN677[234]
- Mr and Mrs Castledine[235]
- WN569[236]
- WN812[237]
- Audrey Mills.[238]

3.189 Some of the themes running through this evidence include:

[228] WD008735
[229] WS000533
[230] WD006602
[231] WS000616 and WS000617
[232] WD006625
[233] WD006603
[234] WD006599
[235] WS000600; Day 78; WD006503/22; WS000609
[236] WD006579; WD006586
[237] WS000681; Day 115
[238] WS000585

- From the 1950s, there was a large amount of paperwork and visits by social workers to the family home before fostering was approved, and, by the 1970s, there were also Police checks.
- Boarding-out allowances were not sufficient; financial support was limited to reimbursement of money spent.
- Some foster parents visited HDLG and took children out on trips before fostering them.
- Some foster parents were approached by Children's Services, others responded to press advertisements, and some applied because they needed the money.
- Some of those fostering in the 1990s and 2000s thought that they received insufficient support, guidance, training and background information about the children in their care.
- By the late 1990s, prospective foster parents were sent on a course run by Children's Services. This focused on children's welfare, but there was no subsequent training.

3.190 In Phase 3, the Panel met with the following:

- Ann Le Rendu, Chair of the Jersey Foster Carers Association;
- Juliette de Guelle, Vice Chair of the Jersey Foster Carers Association;
- June Summer, Chair of the Fostering Panel.

3.191 The following emerged from the consultation:

- there is insufficient support, guidance and training for foster carers;
- several foster carers have ceased fostering because of "*exhaustion within the system*";
- foster carers need to be seen as part of the team around the child. They know the child better than many professionals, as they have care of the child every day;

- communication with foster parents needs to improve. There are significant delays in information being passed to foster carers by those supporting, thereby potentially jeopardising the care of the child.

Current or recent policies, procedures and guidance on fostering

3.192 In October 2012, various policies and guidelines were introduced about fostering. We note these here as they are relevant when considering the adequacy of the Health and Social Services Department's policies and procedures, as well as our recommendations. The existing policies and procedures are set out in: Fostering Panel guidelines; guidelines on the assessment and approval of foster carers; and guidelines on the process to be followed in respect of persons disqualified from fostering, in which Children's Services applied the same requirements as those set out in the *Children (Jersey) Law 2002* in respect of managing a voluntary home or fostering a child privately.

3.193 We also note certain draft policies and guidance, as at February 2014, on other fostering issues, including: exemptions to a foster carer's approval;[239] supervision and support of foster carers;[240] review of foster carers;[241] allegations against foster carers;[242] and employees who wish to become foster carers.[243]

Why were children placed, and then kept, in care?

3.194 As set out at the beginning of this chapter, we are required to consider (in general terms) why children were placed and maintained in children's homes and foster homes in Jersey.

<u>Why were children placed in care?</u>

3.195 In considering this question, we looked, in particular, at the following:

- the prevailing social conditions;

[239] WD009373
[240] WD009374
[241] WD009375
[242] WD009376
[243] WD009377

- the relevant legislation;
- an analysis of reasons for admission to HDLG;
- a selection of individual case histories over the relevant period, and reasons given for children being placed in care;
- data on reasons for admissions to Les Chênes;
- a small selection of documents looking at the approach taken since the introduction of the Placement Panel in 1999.

3.196 The Jersey Care Leavers' Association's closing submissions provide a helpful summary of some of the reasons for children being taken into care, such as:[244]

- parental convenience;
- destitution;
- family breakdown;
- parental "*social inadequacy*";
- criminality;
- bereavement;
- abandonment.

3.197 In considering the reasons for children being placed in care, we are mindful of the prevailing social conditions. We heard evidence in that regard from John Rodhouse (Director of Education, 1973–1989) and from Anton Skinner (Children's Officer, Head of Children's Services, 1986–1995). In his statement,[245] Tony Le Sueur provides a concise history of the child care system in Jersey, and Professors Bullock and Parker also provided a review of services for children in care in Jersey, in comparison with those in the UK.

[244] WD009422/1

[245] EE000038

3.198 John Rodhouse[246] said:

> *"When I arrived in Jersey in 1973 I stepped back into the 1950s. Jersey operated in ways that were very different from the United Kingdom, both in terms of its society and its education system. Life in Jersey was somewhat slower and the Education Service was not well supported by legislation. I say this as a matter of fact and not as a criticism of Jersey, or of the way the States operated … some of the problems Jersey experienced can be attributed to the difference in scale between Jersey and the United Kingdom. However, it is important also to remember that Jersey, through its history, differs from the United Kingdom … I do not think the comparison with United Kingdom is always fair."*

3.199 In evidence to the Inquiry, John Rodhouse said that Jersey in the 1970s and 1980s was not a good place to be poor. There was a lack of welfare provision, aside from Parish Relief. This was subject to the personal judgement of the Connétable and could not always be relied upon.[247] Pauline Vautier had been a CCO since 1978, on the Child Protection Team from 1999 to 2004 and on the Leaving Care Team from 2004 to 2009. She said that the stigma of being dependent upon the Parish changed with the introduction of income support in the 2000s: "*it was a much better, transparent, fair, non-judgmental way*".[248]

3.200 Anton Skinner[249] said:

> *"Poverty was a genuine issue and there were also often ongoing severe mental health problems and parents who simply could not control their children, as well as those with drink and drug problems … There was a recognition amongst the wider community that children in care were deeply complex and troubled children … Le Rocquier School had to enrol many of the children from Haut de la Garenne and the headmaster questioned why his school had to be the one to accept all these 'grossly disturbed children'"*.

<u>The legislative context</u>

3.201 Jersey has a long and proud history of functioning under its own Legislature and Executive. Its legal system derives from Norman law, and, as a Crown Dependency, the island maintains its connection with the UK. Legislative changes in the UK (or, more accurately, England and Wales) appear to have

[246] WS000612

[247] Day 92

[248] Day 85/170

[249] WS000614/4

had an inevitable influence on legislation in Jersey. However, the enacting of legislation in Jersey is entirely independent of and separate from the process in the UK.

3.202 Jersey Laws, the island's primary legislation, though passed by the States Assembly, are formally approved of by Her Majesty in Council.

3.203 Richard Whitehead, a Principal Legal Adviser and Director of the Civil Division in the States of Jersey Law Officers' Department, gave evidence to the Inquiry.[250] He stated that, before 1945, Jersey generally adopted UK legislation.[251] He provided a chronological commentary on the principal child care legislation in force in Jersey as at 1945 and Laws passed from 1945 up to 2013.[252]

3.204 Richard Whitehead also explained that customary law in Jersey played a significant role:

> *"Customary law is the law – the unwritten law of Jersey which is based on Norman customary law – and is obviously of great antiquity. Because it is underwritten it can develop and does develop over time and it is not always the case that subjects need to be covered by legislation, they can be … [and] sometimes are already covered by the customary law*."[253]

3.205 Appendix 7 is a table of legislation relating to children, including the relevant legislation in force in 1945. The key points of the legislative basis for the admission of children into care in the period under review, some of which have already been discussed in relation to the individual children's homes, are set out below.

3.206 In addition to the legislative provisions, placement at residential homes could be organised on a voluntary and private basis by the family of the child in question. This applied whether the home was run by the States of Jersey or

[250] Days 10, 15–16 and EE000261

[251] Day 10/67

[252] Appendix 1 attached

[253] Day 15/96

was a voluntary home. At HDLG, many of the children admitted on a long-term basis were under the care of the States, while shorter admissions were on a voluntary basis and arranged by the family.

The 1935 Loi[254]

3.207 The concept of a "fit person" order was introduced (although the phrase was not used), allowing anyone considered suitable by the Court to assume responsibility for a child judged to be in need of care and protection.

3.208 Approved School orders were permitted by the Court in circumstances where:

- the child was *"in need of protection"* as a consequence of being orphaned or because of parental neglect and thereby had either *"fallen into bad associations"*, had become exposed to moral or physical dangers, or was no longer under proper control; and
- the child had committed a criminal offence.

3.209 *Article 13 of the 1935 Loi* provided an alternative to sending a child to the UK on an Approved School order. Boys under 14 could be sent to the Jersey Home for Boys. Girls under 14 could be sent to the Jersey Home for Girls from 1939.

Public Instruction Committee Act 1946[255]

3.210 This Executive Act set out the admission process to States-run children's homes: children aged under six years were to be admitted to the Westaway Crèche and boys aged between six and 15 years were to be admitted to the Jersey Home for Boys "*and will normally remain there until they attain school leaving age*".[256] A boy admitted "*by order of the Royal Court*" (that is, the island's alternative to an Approved School order) was to remain at the Home until "*the Court has sanctioned his leaving the Home to take up suitable employment*".[257] Girls between the ages of six and 12 could be admitted to the

[254] Loi appliquant à cette Ile certaines des dispositions de l'Acte de Parlement intitulé 'Children and Young Person's Act, 1933 (23 Geo.5, ch .12), confirmé par Ordre de Sa Majesté en Conseil en date du 21 Février 1935

[255] EE000255

[256] EE000255, paragraph 4

[257] EE000255, paragraph 4

Jersey Home for Girls (previously the Jersey Female Orphans Home) and would *"normally remain there until they attain the age of 17*".[258] The Royal Court retained the equivalent power in relation to girls as it did with boys. Applications for admission were to be made to the Public Instruction Committee "*by the Constable of the parish or other competent authority or person concerned*".[259] Only these designated individuals could apply to remove a child from "*any of the said Institutions*". Granting an application would be made only if "*in the opinion of the Committee it was in the interest of the child concerned*".[260] The same individuals were to be responsible for the financial maintenance of children admitted to a home on their application. An application to a home was to be recorded on a prescribed form accompanied by a certificate of health. Save for orders made by the Royal Court, the Public Instruction Committee could refuse admission. The Committee could have a child removed if, among other reasons, "*the conduct of the child is prejudicial to the other children in the home*".[261]

Public Instruction Committee Act 1953 – conditions for the reception of children into the care of the Public Instruction Committee[262]

3.211 This rescinded the *1946 Act*, although the route for admission remained the same: via "*the Constable or other authority or person responsible for the maintenance of the child*". Paragraph 2 formalised the Public Instruction Committee's discretionary power to board out a child received into care, as an alternative to admitting that child into a home. The Committee retained the right to refuse to receive a child into its care and for that child's care to be taken over by the Parish "*or other authority or person responsible for the maintenance of the child*". The Committee's existing power to remove a child once in a home was also no longer explicitly provided for.

3.212 As explained by Richard Whitehead, this was an Executive Act and therefore had no statutory force.[263]

[258] EE000255, paragraph 5

[259] EE000255, paragraph 1 – There is no definition of "*competent authority*" or "*person concerned*"

[260] EE000255, paragraph 6

[261] EE000255, paragraph 7

[262] EE000167

Under the Children (Jersey) Law 1969[264]

3.213 In evidence to the Inquiry, Richard Whitehead commented that, in formulating the *1969 Law*, Jersey drew "*very considerably*" on legislation in England and Wales. He acknowledged that, by the time the *1969 Law* came into force in the island, the equivalent legislation in the UK[265] had already moved on in a number of ways. On a comparative analysis, the *1969 Law* was more closely aligned with the *Children Act 1948*, passed over 20 years earlier in the UK.

3.214 For the first time, the *1969 Law* created statutory routes whereby children could be received into the care of the States:[266]

- voluntary admissions under the Committee's duty to orphaned/abandoned children (*Article 82*);
- parental rights order, whereby the Committee acquired legal guardianship (*Article 83*);
- admission to a "*place of safety"* (*Article 10*);
- remands (*Article 26*);
- admission because child is in need of *"care, protection or control"* (*Article 28*);
- admission under a "fit person" order (*Article 31*), which would last until the child reached the age of 20 (*Article 30*).

3.215 *Article 27* defined the meaning of a child in need of "*care, protection or control*":

> *"(1) A child is in need of care, protection or control within the meaning of this Law if he is under the age of seventeen years and:*
>
> *(a) any of the conditions mentioned in paragraph (2) of this Article is satisfied with respect to him, and he is not receiving such*

[263] Day 15/38

[264] LG000032

[265] Children and Young Persons Act 1969

[266] Mr Whitehead said that this was "the major piece of legislation bringing together and repealing almost all of the existing child welfare legislation in Jersey, with the exception of the Adoption Law": EE000261/14

care, protection and guidance as a good parent may reasonably be expected to give; or

(b) he is beyond the control of his parent or guardian.

(2) The conditions referred to in sub-paragraph (a) of paragraph (1) of this Article are that:

(a) he is falling into bad associations or is exposed to moral danger; or

(b) the lack of care, protection or guidance is likely to cause him unnecessary suffering or seriously to affect his health or proper development; or

(c) any of the offences mentioned in the First Schedule to this Law has been committed in respect of him or in respect of a child who is a member of the same household; or

(d) he is a member of the same household as a person who has been convicted of such an offence in respect of a child; or

(e) the child is a female member of a household a member of which has committed or attempted to commit the crime of incest.

(3) For the purpose of this Article, the fact that a child is found destitute, or is found wandering without any settled place of abode and without visible means of subsistence, or is found begging or receiving alms (whether or not there is any pretence of singing, playing, performing or offering anything for sale), or is found loitering for the purpose of so begging or receiving alms, shall without prejudice to the generality of the provisions of sub-paragraph (a) of paragraph (2) of this Article, be evidence that he is exposed to moral danger."

3.216 *Article 30* established that a "fit person" order was to remain in force until the child reached the age of 20. The phrase "fit person" appeared for the first time in the *1969 Law*. *Article 31* stated that the Education Committee was deemed to be a "fit person" to whom a child could be committed.

3.217 Whereas the Committee had previously had discretion as to the admission of a child into its care, *Article 82* required it to admit the child where it was *"necessary in the interests of the welfare of the child*" and maintain them in care "*so long as the welfare of the child appears to require it*" up to the age of 20.

Children (Jersey) Law 2002

3.218 This Law, as amended since coming into force in 2005, remains the principal child care legislation in Jersey. The bases upon which a child could be taken into care were set out as follows:

- *Article 17* – provision of accommodation for a child for whom no-one bore parental responsibility, or who was lost or abandoned, or whose carer was prevented from providing suitable accommodation.
- *Article 18* – provision of accommodation for a child needing protection.
- *Article 24* – care order for a child suffering, or likely to suffer, significant harm, which was attributable to the care given the child not being what it would be reasonable to expect, or to the child being beyond parental control. This vested parental responsibility over the child with the States of Jersey.
- *Article 30* – interim care order for a child suffering, or likely to suffer, significant harm.
- *Article 37* – emergency protection order.

3.219 There is no general provision within the *2002 Law* that mirrors the duty placed on UK local authorities by the *Children Act 1989* to safeguard and provide for the welfare of children who are in need. However, *Article 2* provided that the welfare of the child must be the court's paramount consideration when determining any question with respect to their upbringing.

Children (Placement) (Jersey) Regulations 2005[267]

3.220 The regulations provide a framework governing the provision of accommodation and maintenance by the Minister for Health and Social Services in relation to looked after children as well as those children for whose welfare the States are under a duty to provide. The schedules to the regulations include details of: (1) what the Minister is required to take into

[267] LG000036, subject to specific amendments under the *States of Jersey (Transfer of Functions No 8) (Miscellaneous Transfers) (Jersey) Regulations 2015*

account when placing a child; (2) the planning of placements; (3) matters to be covered in foster care and placement agreements.

3.221 Regulation 2 imposes an obligation an obligation, "*so far as is reasonably practicable*", to make immediate and long-term arrangements when placing a child and to ensure that the welfare of the child placed is promoted. Schedule 1 sets out the considerations to which the Committee has to have regard when placing a looked after child. These included immediate and long-term arrangements for the child, whether arrangements needed to be made for when the care order was discharged and planning for a permanent placement.

Children (Secure Accommodation) (Jersey) Order 2005[268]

3.222 These regulations prescribe the maximum period for which a child can be kept in secure accommodation – 72 hours in any period of 28 consecutive days – without court authority. A court can authorise a maximum of three months and *"from time to time"* for a period not exceeding six months. Parents of the child have to be informed and, when in secure accommodation, the child has to be visited by someone appointed to do so on behalf of the Committee.

Examples from witnesses and contemporaneous records of the reasons why children were taken into care

3.223 A large majority of the witnesses from whom the Inquiry heard during Phase 1a were admitted into care between the 1960s and the 1980s. Thus, most, although not all, of the evidence collated about reasons for individual children being placed into care cover this period.

1945–1959

- **Giffard Aubin.** He was taken into care during the Occupation, after the Parish Centenier declared his father unfit to look after children. His father complained about a local brothel frequented by the Germans, and Mr

[268] LG000039, subject to specific amendments under the *States of Jersey (Transfer of Functions No 8) (Miscellaneous Transfers) (Jersey) Regulations 2015*

Aubin believed that his reception into care was in retaliation for his father's complaint.[269]

- **WN260.** His father was deported to Germany during the War. Food was scarce during the Occupation, and WN260 turned to stealing to assist the family. He was caught stealing in 1946, aged 12, and sent to the JHFB.[270]

- **WN262**. The son of a divorced mother who worked long hours. He was taken into care around 1951. A policeman arrived at the door one day, when his mother was absent, and took him to the JHFB; he had no chance to say goodbye to his mother. After a period back at home with his mother and stepfather, the latter requested his return to the JHFB. The Centeniers drove him to the home. He was released shortly thereafter, at his mother's request.[271]

- **WN178.** Admitted to Sacré Coeur in 1955 and then Haut de la Garenne in 1961, with the reason given being "*Illegitimate. Mother unable to provide a home*".[272]

- **WN266.** Taken before the Royal Court (apparently by the Centenier) and deemed to be out of control; sent to the JHFB in about 1957. When he was 13 or 14 years old, his mother told him that he would not have been sent to the Home had she agreed to sleep with the Centenier.[273]

- **WN129.** Taken into care along with a sibling and sent to the JHFG because her parents could not look after them.[274]

- **WN208.** An example of a child taken into care because of domestic violence.[275]

[269] WS000001/1
[270] WS000037/2
[271] WS000053
[272] WD000180
[273] SOJP WS000056/3
[274] WS000071/2
[275] WS000076/2

- **WN178.** In 1955, a mother and her illegitimate child were able to stay together while she was resident at Elizabeth House and then at the grandparents' home. When those arrangements came to an end, the child was admitted into care, with the reason give being "illegitimacy".[276]

- **WN340.** Example of an individual having a different understanding of the reason for admission into care from that disclosed by the Social Services file. WN340 says that she was taken into care in 1959, after a teacher notified Social Services of concerns about her mother. WN340 says that her mother was violent and may have had postnatal depression, and that she was admitted into care for her own protection.[277] The case history for WN340 said that the reason for the care order was "*child in need of observation. Petty pilfering; rude and cheeky*". She was sent to HDLG for four years.[278] This case gives an insight into the low threshold applied for admission into care at that time.

- **WN124.** He was admitted into care in the 1960s, as a result of stealing, albeit "*on a large scale*".[279] His case history says that he was admitted to HDLG (supported by Dr Collins, psychiatrist) because he was beyond the control of his mother.[280] His headmaster provided a detailed report, and one of the reasons cited by him was that the school and local shopkeepers were in "*urgent need of protection*".[281]

- **WN126.** Admitted in 1958 to Jersey Home for Boys, *"recommended by Chef de Police because the boy has been stealing".*[282] He spent nearly 10 years in care.

- **WN19.** Was admitted, along with her siblings, to Sacré Coeur[283] (not run or supervised by the States of Jersey at that point) for two short periods

[276] WD000180

[277] WS000143

[278] WD000651

[279] WD000856

[280] WD000853

[281] WD000849

[282] WD000621

[283] As above, the Sacré Coeur Orphanage was established at the turn of the 20th century to address the lack of provision for poor children in Jersey

in the late 1950s. On the first occasion, the nuns suggested admission while the mother recovered from an illness.[284] On the second occasion, the children were admitted for seven weeks so that the mother could work and save for a television.[285] WN19 said that children being admitted into care was the norm on the island. It happened for a variety of reasons: to allow people to work, if children were naughty at home, or if they got into trouble with the police.[286]

- **WN240.** Admitted to Sacré Coeur in 1955/57 when her mother died. Her father tried to look after his children, but *"in those days it was not thought right for a man to look after young girls".*[287] She also spoke of French farmworkers, who came over at certain times of year, leaving children in the orphanage while they worked.[288]

- **Pat Lucas** was not a child in care, but, as a child, lived with her mother in the grounds of Sacré Coeur. No records were available to the Inquiry to verify her account, but her understanding of the reasons for children being admitted on a voluntary basis to the Catholic orphanage in the 1950s was that they included:

    - death of mother;
    - desertion by father;
    - financial difficulties;
    - parental illness;
    - the need for mother to work, and consequent difficulties with childcare;
    - seasonal workers visiting Jersey.[289]

[284] Day 12/3
[285] Day 12/31
[286] Day 12/38
[287] WS000271/2
[288] Day 39/60
[289] WS000095/3

1959–1969

3.224 An analysis of the reasons for admissions to HDLG was carried out, using figures from annual Children's Officers reports to the Children's Sub-Committee (see Table 3.1). The reasons for admission are taken directly from the entries in the minutes.

Table 3.1: Overall Picture of Admissions to Haut de la Garenne[290]

Admissions	1960	1961	1962	1963	1964	1965	1966	1967	1968	Total 1960–1968
Mother's illness	54	13	14	2	2	37	20	46	7	146
Illegitimate						3	5		3	12
Adoption/foster home breakdown	2	8	8		3			1		22
Parents' separation				1		7	6	9	1	24
Homelessness		5	2			1	7		2	17
Parent(s) deceased			4					1	4	9
Social inadequacy of parents/Behaviour problems	13	4	14	4	4	16	18	25	18	116
Committed to care as being in need of care or protection	1	6	1	2	5	12	3	7	7	44
Offenders				18	9					27
Remand/Condition of Probation	1	5	5		8	8	36	6	10	82
Children from mainland/Guernsey needing care			1							1

3.225 One feature of the decade 1959–1969 is the variety of reasons leading to children being taken into the care of the Education Committee and then being placed at HDLG. This resulted in a diverse population being resident in the Home at any one time. The largest intake related to "*mother's illness*" and, on the basis of witness statements and social services records received by the Inquiry, it seems that this referred not only to mental illness and hospital admission but also to mothers going into labour.

3.226 The second-largest intake was as a consequence of "*social inadequacy of parents"* or *"behaviour problems*". These phrases are not found in what was then the only statutory basis for receiving children into care: the *1935 Loi*. *"Behaviour problems*" was used for the first time in the 1962 Annual Report to

[290] WS001178/5

describe behaviour in the home and again in the 1963 Annual Report as a generic phrase to include "*serious truancy"* and *"offenders*".[291]

3.227 "*Social inadequacy of parents*" appeared for the first time in the 1964 Annual Report[292] and then as a category in all subsequent reports. The phraseology may reflect changes in social work approach and practice, as, at that time, the Annual Reports record regular recruitment of qualified CCOs.

3.228 The annual Children's Officers' Reports provided also provided a general category of admission "*at Constable's request*".[293] Although some admissions were described in this way, we note that the Attorney General (AG) advised the Education Committee in 1959 that, at common law, in the absence of a court order, the father's consent was needed to take a child into care.[294]

3.229 Reasons for reception into care included:

- *"because of home difficulties"*;
- *"on recommendation of child guidance clinic"*;
- *"mother's desertion"*;
- *"mother's ill-health"*;
- *"foster home breakdown"*;
- "*adoption breakdown*";[295]
- *"death of mother"*;
- *"homelessness of family"*;
- *"parents unable to provide a home"*;
- *"pending adoption arrangements*";

[291] EE000059/1
[292] EE000060/4
[293] LG000181
[294] WD001175/8
[295] EE000059/8

- *"mother in prison"*;
- *"deserted on the island"*;
- *"up from the [Westaway] Crèche"*.

3.330 The 1964 Annual Report noted that "*nearly half the children"* at Haut de la Garenne were in care because of delinquent behaviour.[296]

3.331 The Education Committee was also willing to make temporary holiday placements. Thus, while the mother worked, the child would spend the summer in HDLG.[297]

3.332 At the beginning of this period, boys and girls from age six could be placed in HDLG. By the end of the period, when the Westaway Crèche had been incorporated, there was a wider age range of placements. The approach then being taken was that siblings, wherever possible, should be kept together. In the 1967 Annual Report, the Children's Officer, Patricia Thornton, saw the broad age range as a virtue of the Home.

3.333 **WN124.** As above, the reason noted in WN124's admission records was *"psychiatric recommendation following difficulties at home*". A psychiatrist writing to Patricia Thornton in 1963 recommended that the best place for the "*severely disturbed*" nine-year-old (WN124) was HDLG "*where he would have the stable environment he lacks, where the staff will be able to supply the discipline he needs, together with the affection and understanding he has so lacked for many years*".[298]

3.334 **WN120.** This case provides an example of the combination of factors leading to admission into care in the early 1960s. The parents were immigrants with alcohol abuse problems, the father was in prison and there was a concern that the family could be evicted from the island. There were also housing issues, resulting in makeshift accommodation. Eventually, the mother was also sent to prison and WN120 was admitted to the care of the States.[299] She

[296] EE000060/3

[297] WD000885; WD000884

[298] WD000852

[299] WD001325/54

was admitted to HDLG as there were difficulties in finding foster carers for a Catholic girl.[300]

3.335 HDLG was viewed, at least by some, as an environment that would benefit children growing up in difficult home circumstances. An educational psychologist's report in 1969 on WN184's recommended placement said: "*at Haut de la Garenne he would have a much better chance to mature in personality and identify with the values of the Children's Home and of society generally*".[301]

3.336 **WN43.** As a "babe in arms", he was placed at the Nursery Unit at HDLG. His siblings were also placed there, on the basis "mother unable to cope".[302]

1970–1986

3.337 The largest number of admissions (to HDLG) during the period from 1970 to 1979, under the *1969 Law*,[303] were voluntary admissions pursuant to the Committee's duty to orphaned/abandoned children (*Article 82*) and admissions under a "fit person" order (*Article 31*). Children who were admitted into care under this Law were in the care of the Education Committee, and were then placed by the Education Committee at HDLG, or elsewhere.

3.338 Examples of more specific reasons given for admission to care are found in the records as follows:

- **WN180.** Admitted in 1970 as "*in need of care, protection or control*", the specific reason being "*missing from home – request of Probation Officer".* The witness gave evidence that she ran away from home and told her Probation Officer that she did not want to return home to her parents.[304]

[300] WD001325; WD001286; WD001317

[301] WD001235

[302] WD000930

[303] WD002622/14

[304] WD001713; WD001703

- **WN397.** Admitted in December 1970 under a care and protection order, with the specific reason being "*mother unfit to care through drink*".[305]

- **WN151.** Admitted to HDLG in February 1971 "*to be employed as a trainee girl*".[306] She was aged 15 at the time, and was in a relationship with an older man.

- **WN391.** Admitted to Brig-y-Don on two occasions in the early 1970s before spending various other periods at HDLG between 1975 and 1977, and between 1980 and 1985. The reason for care is given as "*beyond control*".[307]

- **WN121**. Admitted into care in 1972, after being placed on probation by the Court. The specific reason is recorded as "*breakdown of home relationships and request of Senior Probation Officer*".[308]

- **WN67.** Placed at HDLG in 1976, on the basis that the "*child refused to go home".*[309]

- **WN594.** Admitted to HDLG in 1976 on remand.[310]

- **WN23.** Admitted to Brig-y-Don on several occasions in the late 1970s, before moving on to Clos des Sables and foster care. The reason given was *"mother admitted to hospital*" (*Article 31*).[311]

- **Darren Picot.** Admitted to Brig-y-Don in 1977, when only a few months old, with the specific reason for admission being "*hospital recommendation*" (*Article 82*).[312] He then moved on to various other homes over the 1980s and 1990s.

[305] WD001666
[306] WD001680
[307] WD003630
[308] WD001641
[309] WD003458
[310] WD003074
[311] WD000162/2
[312] RS000615/110

- **WN80.** Several admissions to La Preference from 1979 – reason given as *"mother's admission to hospital*".[313]

- **WN597.** Admitted in May 1982 to HDLG for "*disruptive/unruly behaviour at home".* He was there for around six to 12 months.[314]

- **WN633.** Admitted to La Preference, aged four, in 1983, due to mother's hospitalisation.[315]

3.339 The Lambert and Wilkinson Report (1981), on "Inspection of The Children's Section",[316] looked at general issues regarding children being taken into care, and highlighted:

- In Jersey, 11.5 children per thousand were in care, compared with an overall figure in England of 7.7.

- The following factors were thought to contribute to such a high number of children being in care in Jersey:

    - the lack of a statutory duty to provide preventative child care. meaning that children were received into care for a short period of time rather than remaining in their own homes;

    - the availability of residential child care resources (space for over 50% of the children in care) may have reduced the pressure to seek alternative methods of care*: "a tradition of assuming close quasi parental responsibility for the children in the care of the Committee, and the availability of predominantly long-term residential accommodation both support this and may militate against current professional policy which seeks to shorten to the briefest reasonable length the time a child is in care"*;

    - factors in the social structure, such as the high incidence of marital breakdown, alcoholism and psychiatric illness; housing

[313] WD004104
[314] WD003425
[315] WD004087
[316] WD007382

and accommodation problems; migrant workforces; and the number of illegitimate births, albeit that this had reduced in recent years;

- 31% of children in care were over school leaving age and, of those, about half had been in care for over 10 years and had experienced "*a full childhood in care*".

3.340 Lambert and Wilkinson also analysed the details of children admitted to HDLG over the previous two years.[317] They noted that 65% of the 233 admitted stayed for less than two weeks.

3.341 When looking at the emergency placements, they noted:

> *"It would seem that the boundaries to short stay admissions are drawn rather too liberally and that some narrowing would be in children's interests."*

3.342 An analysis of reasons recorded for admissions to HDLG between 1959 and 1984 was produced by Peter Wall in July 2009. This was part of Operation Rectangle's "Analytical Summary of Historical Child Abuse",[318] and the findings are incorporated into the Inquiry's own analysis set out above.

Late 1980s onwards

3.343 We note that, in 1989, Phil Dennett (while working at Heathfield) was asked to lead a project to incorporate community-based work to avoid the necessity for admissions to care.[319] This was the beginning of a considerable amount of work that took place, largely at Heathfield and Brig-y-Don, to develop community-based work and preventative strategies, in order to avoid some unnecessary admissions to care. By 1998, this had developed into a huge operation catering for 60–70 young people, but it was not run by qualified social workers.[320] Young people at risk of reception into care were collected from school and taken out on activities or taken to Heathfield. The development of respite and shared care arrangements allowed some to have

[317] WD007382/50

[318] WD008622/11

[319] WS000628/4

[320] Day 95/16 and 32

occasional or regular overnight stays at Heathfield. Tony Le Sueur thought that preventative child care could have been run from a youth centre, he told the Inquiry.[321]

3.344 According to Phil Dennett, no qualitative assessment of the work of the preventative centre was carried out by Children's Services. No system for monitoring the outcome for children was in place, and there was no data to indicate whether the number of children received into care had been reduced. Phil Dennett said that, when he left Children's Services, *"Jersey had not got its head around that performance management agenda".*[322]

3.345 This makes it impossible for us to assess the success of these schemes, but we at least note their existence as demonstrating a will, by this stage, to make efforts to prevent children from being admitted into care.

3.346 When Sean McCloskey was a staff member at Heathfield (during the late 1980s and early 1990s), he noted that admissions were made following a referral by a social worker, usually related to family breakdown. He said that, at that time, residential care was seen as being the last resort, and attempts would be made to place the child with extended family or with others first.[323]

3.347 A Placement Panel was created from around 1999,[324] to allocate residential and foster placements for those children who were admitted into care, although this does not touch on *whether* a child should have been admitted into care in the first place.

3.348 In December 2002, a letter was sent from Tom McKeon (Director of Education) to Anton Skinner and Brian Heath, about the arrangements as to the placement of children immediately following Dr Kathie Bull's Report. It was noted that a group of senior officers would be established, with the mandate to determine residential placements for children aged 11–16. However, it would not be possible to include Les Chênes in this arrangement, given the

[321] Day 90/28
[322] Day 95/140
[323] WS000576/6
[324] WD009335

need to make separate provision for children placed on secure remand and those in residential care.[325]

3.349 More recently, in 2009, a document entitled "*Children's Service – Placement Processes*" set out the formal processes used to decide whether a child should be taken into care and detailed the processes for managing any subsequent placement. Initially, there would be intervention from social workers and/or Police, and, if a need for placement was identified, placement with extended family or friends was to be explored as a *"first option*" (unless there were identified risks in making/allowing such a placement). The second option was to explore foster care, with placement in a residential home being considered as a third option.[326] If none of these options is possible, the process indicates that a bespoke placement should be considered.

3.350 By 2013,[327] placements were considered by the Placement and Resource Panel, under the head of the Children's Service and Children's Executive. Individual cases were presented to the Panel by a CCO. This might be an update on a child already placed, or a request for placement – for example, overnight respite, outreach support, intervention by the Intensive Support Team, a foster placement or respite foster care.

3.351 A briefing paper from 2015[328] noted that an increasing number of children at risk were becoming "looked after". However, as of August 2014, the rate of looked after children in Jersey was 39 per 10,000 – compared with a UK national rate of 60 per 10,000. At the end of March 2015, the rate in Jersey was 50.5 per 10,000, and this was anticipated to rise to 65, which would be in line with the UK average.

Why were children maintained in care?

3.352 The legislative basis for maintaining children in care varied over the decades, and the legislation in force at any one time permitted a child to remain in care

[325] WD009147

[326] WD009341

[327] WD009222

[328] WD009331: Produced by Paul Watson (Senior Social Work Practitioner Seconded to System Redesign) and Andrew Heaven (Assistant Director Commissioning)

up to a prescribed age. Under the *1935 Loi*, the age was 16 for boys and 18 for girls. This was increased under the *1969 Law* to the age of 20 for both boys and girls. Under the *2002 Law*, care orders can remain in force until the child reaches "*full age*" (not defined) unless the order is discharged before then by the court (*Article 66*). Emergency protection orders can last only up to 28 days, and there are powers to discharge early or to extend this period (*Article 40*).

3.353 A number of the witnesses called in Phase 1a of the Inquiry complained that they felt forgotten once admitted to care,[329] or that they did not understand why they remained there for so long. As set out above, some witnesses recalled (and their records substantiated) being admitted for relatively minor behavioural problems, but the result was spending many years in residential institutions. The 1981 Lambert and Wilkinson Report highlighted that over half of the children resident at the time of the Report had been in care for between one and five years; nearly a fifth had been in care for up to 11 or 12 years.

3.354 Individuals were discharged from care for a number of different reasons. In the pre-1960 period, the Public Instruction Committee minutes[330] note that, where children had been admitted under a court order, the AG's approval was needed if a child was to be discharged to enter employment. In such cases, the Committee would often express a view on the suitability of the job, whether the child's home conditions were suitable for a return, and whether it was in the child's interests to remain at the institution.

3.355 Some examples from the annual reports in the 1960s note discharges from HDLG for reasons including: "boarded out with relatives"; "residential job"; "rehabilitation with family"; "training home for girls"; "training home in England"; "Boys' Army"; "probation hostel in England"; "maladjusted hostel for boys"; "Indefatigable [sea training school]"; "lodgings"; "to family group home"; "vocational training homes in England"; "transferred to staff at Haut de la Garenne";[331] and "discharged on reaching the age of 18". During this period, it

[329] E.g. WD004539/10

[330] See Day 144

[331] EE000063/12

would appear that that Superintendent had the authority to discharge a child from HDLG where he felt it had made no difference to their behaviour, in circumstances where the child had not been admitted by court order.[332]

3.356 We note that, under *Article 30(9) of the 1969 Law*, a child could be discharged from care and a "fit person" order revoked where the Education Committee represented to the AG that it was in the child's interests, and the AG made an application to the court. Furthermore, under *Article 32*, a child could be returned to their parents while still in care and then could be discharged upon application to the Royal Court if it was no longer necessary for them to be in the care of the Committee.

3.357 Notwithstanding these provisions, Lambert and Wilkinson came to the view, in their Report, on a review of the care records, that a "*care episode"* in Jersey was likely to be longer than one on the mainland. It was noted that:

> *"A tradition of assuming close quasi-parental responsibility for the children in the care of the Committee, and the availability of predominantly long term residential accommodation, both support this and may militate against current professional policy which seeks to shorten to the briefest reasonable length the time a child is in care."*

3.358 We note that, in 1985, correspondence between the Children's Officer (at that time, Terry Strettle) and Richard Davenport (CCO) referred to their prime aim as being to "*reunite parents and children*".[333] However, we have not seen any specific policies or practices suggesting a model of intervention that worked to assist a child to return to their family after they had been admitted into care, until the late 1980s and early 1990s.

3.359 In evidence to the Inquiry, Geoffrey Spencer (former manager of Heathfield) said that he did not feel that there was any commitment from Children's Services in relation to getting children out of care. Overall, he felt that the system was not fit for purpose, by today's standards.[334]

[332] E.g. WN124 in 1966: WD000837

[333] WD000347

[334] Day 75/88

Les Chênes

3.360 Les Chênes opened in 1977 and is considered separately on the issue of "*why children were placed and maintained in these services*". Les Chênes admitted children on a different basis, from residential care homes and foster homes. Les Chênes was, effectively, a hybrid Approved School/community home with education.

3.361 Under the *1969 Law*, the Education Committee was required to ensure adequate provision for the care and custody of young offenders. The Committee was principally concerned with juveniles (aged under 16) on remand awaiting trial, or those found guilty of criminal offences and committed to the care of the Committee by the Court. When it opened, Les Chênes gradually took over the remand role that previously – and controversially – had been fulfilled by HDLG. Les Chênes' admission policy[335] stated that the following would be admitted:

- offenders committed to the care of the Education Committee for long-term treatment (*Articles 24 and 31, 1969 Law*);
- children in need of residential education in a secure environment, or who were not necessarily offenders but whose behaviour was such that they were committed to the care of the Education Committee under *Article 27 of the 1969 Law* as being "*in need of care, protection or control*"; and
- in exceptional circumstances, those who the Education Committee decided to admit without the need for court action.

3.362 The *Children and Young Persons Act 1969* abolished Approved Schools in England and Wales and replaced them with Community Homes with education. Les Chênes was, in our view, specifically tailored to be the successor to the Approved School/remand placement.

3.363 A notable feature in the evidence given by several witnesses is a lack of understanding on their part as to why they were placed at Les Chênes:

[335] WD004278

- **WN153.** Admitted in 1984 – *"Les Chênes had a reputation of being a school for children who were challenging. I never understood why I was sent."*[336]

- **WN624.** Recalls that her mother told her that the Court ordered her admission to Les Chênes, but *"I never found out the real reason why I was sent there"*.[337]

- **WN623.** Recalls the police speaking to her, but *"I do not remember being told why I was being sent to Les Chênes but I do remember it being on a 'voluntary' basis, rather than compulsory"*. She suspected, however, that the real reason was that her mother used influence she had to have her admitted.[338]

3.364 Another theme that emerges from the evidence is the degree of confusion or resentment among those who were not admitted to Les Chênes on remand or as a young offender:

- **WN145.** Admitted between 1981 and 1984. He stated: *"I was not sent there for being a criminal or by order of any court. I was there because I was from a dysfunctional family and had a father who couldn't care for me."* He discussed what he perceived to be the negative impact that this had on his life and the consequence of being failed by the Jersey care system.[339]

- **WN73.** He was admitted to Les Chênes about 20 years later than WN145. He also describes the negative impact that admission (under a care order) had on his life, as he was forced to mix with young people who were criminals. He was *"fully aware that I was being taken to a remand centre even though I had not committed any offences. I would*

[336] WS000675/9
[337] WS000509/3
[338] WS000508/2
[339] WS000485/6

often say to staff that they did not lock up adults in prison [for the reasons he was admitted] *but my comments were dismissed".*[340]

3.365 Under Mario Lundy's tenure, between 1986 and 1996, numbers admitted to Les Chênes increased rapidly, particularly in the 1990s. This followed a revised admissions policy that allowed for a child to be admitted for long-term placement "*on the imposition of a Probation Order with residence at Les Chênes being a condition of that order*".[341]

3.366 A sample of data on the reasons for admission to Les Chênes, the number of admissions for an individual, how long they stayed and any notes on discharge was prepared for the Inquiry by the States of Jersey.[342] It is noteworthy from this sample that, while there were a significant number of remand placements, there were also admissions to Les Chênes for those in need of care, protection or control.

Findings: Why children were taken into, and kept in, care

3.367 In general terms, the reason for children being taken into care was that it was considered that they satisfied the legislative threshold that was in place, under either the *1935 Loi*, the *1969 Law* or the *2002 Law*.

3.368 The reason for their being kept in care is that the relevant legislation provided that they remained in care until they reached a certain age, unless and until an application was made for their discharge. However, as with the above, this provides only a superficial answer to the question.

3.369 It is apparent that, particularly before the *1969 Law*, children were taken into care without specific reference to the legislative framework in force at the relevant time.

3.370 Although the legislative bases for taking children into care were widely drafted, we consider that some children were received into care without a lawful basis. For example, in the 1960s, children were taken into care and admitted to HDLG for reasons including *"social inadequacy of parents or*

[340] WS000443/8

[341] WD004214

[342] Appendix 2 of the closing submissions of Counsel to the Inquiry

behaviour problems" (116 cases) and *"parents' separation"*, which do not appear to fall within the *1935 Loi*.[343] In the late 1970s and early 1980s, children were taken into care in order to give their mother a rest, or to provide a form of safety valve where preventative action was being taken by the social worker.[344] It follows that their rights as children were disregarded. We consider that Jersey has a long history of public authorities having insufficient regard to the law in relation to children.

3.371 It is clear to us that, in the 1940s and 1950s, there was no real expectation that a child in Jersey, once admitted into care, would ever leave the care system. No doubt for that reason, there was no specific provision for the return of children to their birth families, although this does appear to have happened on occasion.

3.372 On the documentation and evidence before the Inquiry, it is clear that, at least up to the mid-1980s and the closure of HDLG, the placement of children in residential facilities reflected the availability of such places on the island and the lack of alternatives, notably with foster or adoptive families. Whether the needs of the child were best met in a residential facility does not appear to have been a consideration at this time.

3.373 During much of the initial period, there was no consistency in the approach taken when considering whether the child's circumstances justified removal from the family home. For example, there were cases in which it was said that the child had "*behaviour problems*"(for example, being involved in "*petty pilfering"* or being said to be "*rude and cheeky*"), whereas others clearly met the legislative threshold. In the former instances, relatively minor social problems were dealt with by the removal into care of the child. Such a draconian step paid no regard to the rights and needs of the child.

3.374 Until the late 1980s, there was no system for providing parents with assistance in the home, which could have avoided the need for removal; a parent who sought assistance from the Parish was subject to the unregulated judgement of the Connétable. As was noted by Lambert and Wilkinson in

[343] LG000216

[344] WD007382/50

1981, there was not a statutory provision for carrying out preventative child care – and there still is not. In comparison, the *Children and Young Persons Act 1963* in England and Wales allowed for expenditure to prevent a child from being admitted into care. This seems to have created a situation in Jersey in which children were received into care for short periods when they should more appropriately have remained in their own homes. The creation of a statutory duty for the carrying out of preventative child care might well remove the need for taking some children into care. Explicit legislation would reflect the States' commitment to preventative work.

3.375 The approach was generally reactive, with no formal criteria for admission into residential care in terms of assessment of degree of risk. We acknowledge that *Article 28 of the 1969 Law*, and *Article 2(3) of the 2002 Law*, did involve a risk assessment before children were placed under a care order.

3.376 There was no adequate review of placement, and, much of the time, information on the wishes of the child was not sought. There was a pattern of maintaining children in residential homes for an excessively long period. Many of the young people at HDLG were going home at weekends, which raises the question of why many of them remained in care. At least up to the late 1980s, there was no substantial model of intervention, no "*this is what we're going to do to assist your return to your family on a permanent basis*". As pointed out by Lambert and Wilkinson in their 1981 Report, circumstances in Jersey militated against the professional policy, at that time, to "*shorten to the briefest reasonable length the time a child is in care".*

3.377 The mechanism for removing a child from care was inadequate. Although the States of Jersey had the legislative power to discharge children from care when it was in the best interests of the child, at least up to the late 1980s/early 1990s, there does not appear to have been any system for proactive consideration of this: the child was effectively abandoned. This is one of the reasons for children remaining in care.

3.378 Under Mario Lundy's term of office at Les Chênes (1986–1996), a revised admissions policy was introduced that allowed a child to be admitted for long-term placement at Les Chênes "*on the imposition of a Probation Order with*

residence at Les Chênes being a condition of that Order".[345] The Education Committee did not retain adequate control in practice over long-term placements with such a condition. Thus, as late as 1996, Jersey was using an outdated model of behaviour management instead of a welfare-based approach for young offenders and children in need.

[345] Les Chênes Admissions Policy, Day 55 [WD004214]

CHAPTER 4

Did the States of Jersey Adequately Manage the Establishments in which it Placed Children?

Introduction

4.1 We are asked, under Term of Reference 2, to determine the organisation (including recruitment and supervision of staff), management, governance, and culture of children's homes, in which abuse has been alleged, over the relevant period, and to consider whether these aspects of these establishments were adequate. In the vast majority of recent or current children's homes (for example, Field View), we have not received any allegations of abuse and therefore we have not analysed these Homes in this chapter. The overlap between the "management", "organisation" and "culture" of the various Homes has meant that these have often been considered together rather than in separate sections. The management of a Home is dependent on its organisation and will inevitably have an effect on its culture. Governance has been reviewed separately where possible, but there are instances where there is very little evidence on the subject of "governance" of a particular establishment.

4.2 In terms of the management, organisation and culture of the Homes, we looked at it from the perspective of those placed in the Home, the staff working there and those having contact with the Home, the Children's Officers and child care officers (CCOs). In addressing the issue of governance, we considered, among other things, the oral evidence given to the Inquiry in Phase 1bb and the documentary evidence from the various committees who had oversight for the institutions.

4.3 We have considered whether the "management", "organisation" and "culture" and "governance" of the Homes was "adequate" in the context of the standards that existed at the time rather than those of the present day. Standards are not tested against the best practice at the time, but by what

was considered reasonable or good enough practice during the period under review.

4.4 In some instances, there is insufficient evidence to come to a concluded view on "adequacy" due in part to the passage of time. That judgement requires reliable evidence as to events and as to contemporaneous standards up to 50, 60 or 70 years ago. We have attempted to obtain such evidence where possible, from contemporaneous reports, witness evidence and policies and procedures.

Jersey Home for Boys and Jersey Home for Girls

4.5 In the case of both the Jersey Home for Boys (JHFB) and the Jersey Home for Girls (JHFG) some of the Homes' residential population resulted from placements that were a direct alternative to being sent to an Approved School in the UK.[1] The management and organisation of Approved Schools in the UK operated under an entirely separate regime to children's homes. They were run on far stricter and more regimented lines than residential children's homes.

4.6 These placements meant that young offenders in Jersey were placed alongside children who were in care because they had been abandoned, mistreated or had been orphaned. The difficulty facing those managing the Homes is reflected in an entry in the Public Instruction Committee (PIC) minutes for 1954.[2] The Superintendent of Jersey Home for Boys asked the Committee to remove a difficult child to an Approved School in the UK. The Committee refused, saying that the child could receive the necessary control and discipline in the Home.

<u>Jersey Home for Boys</u>

4.7 There are accounts of large resident populations in the late 1940s and for some residents the JHFB was regimented and the routine inflexible. To others, it was less regimented:

[1] 1935 Loi – Article 13

[2] The Public Instruction Committee became known as the Education Committee in 1955

4.7.1 Giffard Aubin (1943–1951). "*Although the boys were given a lot of chores to do, such as washing up, polishing the floors and potato peeling, we also used to have outings and sandcastle competitions".*[3] Visits by parents were prescribed under legislation.[4] Giffard Aubin remembers his parents visiting once a month.

4.7.2 WN258 (1942–1953). *"We worked daily at the home, scrubbing floors, polishing floors in long rows of boys, using bumpers to highly polish the floors, working off dining tables, cleaning windows, washing walls, sweeping up outside, mowing the grass, ploughing and planting the fields. We had six boys at the time to pull the plough*[5] *… From the time the boys had finished school and were preparing to go off and find work outside they worked in the home or sometimes they were sent out to help local farmers. These boys were called 'House Boys'. Meals, were held in complete silence".*[6] He left the Home when aged 16 and joined the Merchant Navy.

4.7.3 WN227. "*There was a routine for everything at the Home … no excuse for the children not to be where they should be … each boy was given an identity number. Most of the time we were known by our numbers rather than our names".*[7]

4.7.4 WN156 (1947–1954). "*The regime …. was very harsh and there was much hierarchy … Boys would be employed by the Masters to control the other boys. Those boys who were permitted were allowed to exercise the inflicting of corporal punishment by means of a cane, coat hanger or occasionally the 'leather' or slipper.*"[8]

4.7.5 WN266 (1957). "*The bells governed the daily routine, from getting up in the morning to going to bed at night. At weekends, we would be*

[3] Day 8/29
[4] EE000255
[5] WS000035/4
[6] WS000035/7
[7] WS000520/5
[8] Day 16/71

given chores to do such as sweeping or peeling potatoes. There was never any time to put aside for us to play or just be children."[9]

4.7.6 WN262 (1955–1959). He recalled being dragged off by two Centeniers and subsequently being beaten by staff at the Home, which he thought was "excessive force". He also said: "*I had some damn good times at the Home too, going canoeing and then going on summer camps, they were wonderful times.*"[10]

4.7.7 Barry Ford (1957–1960). He recalled that some boys would be allowed pets at the home and also "*in the summer we would go swimming or to the beach. There was always something to do … A film every Saturday … Once we had lunch on a Sunday … we would all go down to the big hall where some of us were given pocket money".*[11]

4.7.8 WN260 (1946–1949). He recalled that when he reached 15 he was summoned to the Superintendent's office and told that he was free to go.[12]

4.7.9 Malcolm Carver (1944; 1946–1951). He remembered the routine that began at 7am: "*Go off and wash … get dressed, make your bed, then troop down … we used to fight to get down first because the first one down carried the porridge bowl in, so the end of the dishing out he got to scrape it out. That's the best part of porridge … we walked to school … we had a coach back at lunchtime, take us back for lunch, then a coach back". "Boys had a box to keep things in."*[13]

4.8 From the accounts of those placed there as children, there is little evidence available to the Inquiry as to the management and organisation of the JHFB in this period. However, more of an insight can be gained from contemporaneous records.

[9] WS000056/5
[10] WS000053/5
[11] Day 38/22
[12] WS000037/4
[13] Day 9/14

4.9 The positions and titles “Superintendent” and “Matron” were well established by 1945 as the senior management within a children’s home.[14]

4.10 WN972 was Superintendent during the Occupation and up to 1947. He was replaced by WN547, whose wife was appointed Matron. Gifford Aubin told the Inquiry that more staff were appointed at this date and all seemed to have a background in the Armed Forces. WN547 had been a Captain in the Army.

4.11 In January 1946, the Public Instruction Committee inspected the JHFB and found that living conditions were below standard. There were large, drab dormitories that were *“having an undoubtedly depressing effect on adolescent minds”.* The Committee recommended major refurbishment: the evidence received by the Inquiry suggests that this never took place.

4.12 In 1949, the Medical Officer for Health (MOfH)noted the overcrowded conditions (91 residents) and asked the States of Jersey for money to defray the cost of boarding out some children. Although we do not know whether such funds were specifically received, records suggest that, in 1950, the MOfH was attempting to increase the number of children being boarded out and noting that they should be paid a reasonable amount. Furthermore, in 1951, a Ms Gracey was asked by the Public Health Committee to devote some of her time to foster children, and as above, she completed her first annual report in March 1951. She noted an “*increase in the number of children boarded out during the year”.*[15] This suggests that the MOfH’s request was, at least to some extent, heeded by the States of Jersey.

4.13 In 1952, WN547 was replaced by WN558, who, according to WN259, “tried *to change things at the Home by getting us vests, underpants and slippers …. (and) pocket money”.* In contrast, WN494, a staff member at the Home in the 1950s, remembers WN558 as being “*very severe”.*

4.14 There is very little evidence available to the Inquiry about the experience and training of staff recruited to the JHFB, or of training made available to staff while employed at the Home. However, we do know that WN494, after

[14] Curtis Report (1946)
[15] WD008742/3

completing National Service, worked in two remand homes in the UK as Supervisor/Instructor. He had no care qualifications and was accepted as a Housefather at the JHFB (without an interview) in 1954: *"In those days, you were expected to know pretty well what you had to do, to do your job."*[16] It was a mixture of "*experience and common sense".* We also know that prior to being appointed Superintendent in 1955, George Maggs had been the Youth Organiser at the Jersey Youth Movement. In 1959, with the approval of the Education Committee, he and the Deputy attended a three-week refresher course arranged by the Home Office.

4.15 WN494 estimated that there were approximately 50 boys in residence.[17] By then, boys were divided into groups: seniors aged 13 to 15; juniors aged nine to 12; and small boys aged six to eight. Below the Superintendent were a Housefather in charge of seniors and a Housefather in charge of juniors, neither of whom had any assistants. Two Housemothers were employed to look after the small boys; each group had a relief staff member to cover, in the absence of whom the Superintendent would stand in. There was also a cook, a kitchen assistant, two cleaners and two sewing ladies. The job of Housefather was full time:

> "*Hours of duty about twenty-four hours really and we had one and a half days off a week … it was really a 24/7 job overseen by the Superintendent … it was a hard job."*[18]

4.16 WN494 provided an account of how the JHFB was managed. When boys arrived for the first time, little was known about their background save that "*they were probably* [from] *poor home conditions*". There was "*no handover … they're all treated the same and we try to make them happy".*[19] He describes his first impressions when he arrived in 1954 as: *"very regimented …* [boys] *were not allowed to talk in the dining room. You have to make sure that they did not talk, you'd send them out to the Superintendent's office and he'd give them the strap".* The daily routine was prescribed in detail for both staff and boys.

[16] WD006718/17
[17] WD00671
[18] WD006717
[19] WD006951/5

Rules and discipline

4.17 In 1951, the UK introduced secondary legislation concerning the administration of children's homes, accompanied by a: "Memorandum by the Home Office on the Conduct of Children's Homes".[20] The legislation prescribed the punishment limits including, for example, restricting its use (other than smacking a child's hand with a bare hand) to those in charge of homes (or in their absence, the deputy), precluding corporal punishment against girls over 10 or boys over school leaving age (other than caning over the clothes), and precluding caning in the presence of another child. Corporal punishment in Approved Schools was regulated by the Approved School Rules 1933 (as amended in 1949). No equivalent legislation existed in Jersey, despite the Public Instruction Committee deciding, in 1948, to revise the rules. In 1962, the Homes were still being run on rules drafted in 1924, as demonstrated by the fact that the Children's Sub-Committee Minutes of 25 October 1962 make reference to the Jersey Home for Boys Rules 1924.[21] The entry suggests that the Rules envisaged corporal punishment (no copy has been disclosed to the Inquiry).

4.18 WN156 (1947–1954), in his statement, described how corporal punishment was administered:

> *"The 'leather' was a leather belt … generally applied across bare flesh … applied to your bare backside … the cane and stick would also be used as management and to maintain, as the staff saw it, discipline".*[22]

4.19 There are entries throughout this period in the JHFB punishment book (no equivalent for the JHFG) that record strapping for "*bullying*" and for sexual assault by older boys on younger boys. Strapping was also given for bedwetting, talking in the dining room and being late for meals. The records show that punishments were given in front of other children.[23]

[20] Bullock Report EE000136/11

[21] WD001189/81

[22] Day 16/72

[23] Day 144: extracts from the punishment books

4.20 The boundary between what was considered acceptable use of corporal punishment and that considered unacceptable is recorded in Public Instruction Committee minutes in 1954. A Housefather at the Jersey Home for Boys resigned, complaining about the use of the strap by a senior member of staff. The Housefather's concern, shared by his colleagues, was the excessive use of the strap rather than the fact of its being used: "*We didn't like the strapping all the time."*[24]

4.21 The Public Instruction Committee carried out a "*prolonged and careful consideration of all the facts*" and found that there were "*irregularities and errors of judgement".* The senior staff member concerned resigned and the Housefather was persuaded to withdraw his own resignation.

4.22 Bedwetting attracted both emotional and physical punishment according to the witnesses who gave evidence in Phase 1a of the Inquiry. Bedwetters were known as "*tunnyfishers*" and were given the strap. If they wet the bed a second time overnight, they had to parade with the wet sheet tied over their head (with a knot tied under the chin) and then wash the sheet in cold water in the yard.[25]

4.23 WN258 suffered this punishment on two occasions and was also lashed by the older boys with stinging nettles. Other witnesses describe the same punishment for bedwetting.[26]

Jersey Home for Girls

4.24 The Inquiry received little evidence about the JHFG during the period under review, which is no doubt explained by the fact that it existed many decades ago. Three former residents gave oral evidence to the Inquiry and statements and documentation from seven other witnesses were read into the record.

4.25 Violet Renouf (1942–1951) said[27] that she was placed at the JHFG aged six; her father had abandoned her mother, leaving nine children. She described a

[24] WD006952/13
[25] Day 16/76
[26] WN261: WS000048; WN262: WS000053
[27] Day 8

very strict regime, and girls were required to do chores. Discipline was maintained by corporal punishment and the use of an isolation room[28] for the more serious incidents. She recalls life as being "*hard, very hard".* She was not visited by her family.

4.26 She said that the girls had to queue for everything. They were not allowed to associate with boys. If they did so and the staff discovered the fact, the girls were subjected, whether they consented or not, to an intimate physical examination by a male doctor.

4.27 Winifred Lockhart[29] (1949–1950; 1953–1959) was first placed in Westaway Crèche before being transferred to the JHFG. Her mother died shortly after she was born; she never knew her father. In 1958, she was moved to the JHFB (when it began accepting boys and girls, before it became Haut de la Garenne (HDLG)) and recalls towards the end of the time at the Home being visited by Patricia Thornton (Children's Officer) and being spoken to directly by her.

4.28 As with the JHFB, some girls were subject to assessment by the Medical Officer for Health (MOfH). The result was that some were sent to St Saviour's psychiatric hospital and others "*sent to a home for naughty girls".*[30] The girls who were sent to a remand home in the UK were described by staff as "*the wicked ones".*

4.29 The girls were bathed once a week, with three or four girls bathing together.[31] They were all dressed in identical clothing and were easily recognisable as girls from the Home.[32] They were allowed to watch television on a Saturday evening, read books, do jigsaw puzzles and skip in the yard.[33]

4.30 The Public Instruction Committee minutes for the period disclose the following:

[28] A locked bare room with a mattress on the floor
[29] Day 11
[30] WS000002/5
[31] WS000078
[32] WS000665/7
[33] WS000665

4.30.1 November 1946. Reports by the Secretary to the Committee noted that the Matron was unable to carry out her duties in a satisfactory manner and that the standard of discipline had deteriorated at the Home. The Committee's recommendation was that the permanent staff all be replaced as soon as possible. The evidence obtained by the Inquiry does not clarify whether this in fact happened.

4.30.2 April 1948. Noted that there were insufficient staff to run the Home; additional staff to be engaged and accommodation provided. Again, evidence obtained by the Inquiry does not clarify whether this in fact happened.

4.30.3 June 1949. The Committee informed the Matron that she was the only member of staff permitted to "*award punishment*" whether corporal or otherwise. We note that this is in line with the standards in the UK as set out in the 1951 Administration of Children's Homes Regulations.

4.30.4 July 1952. Direction given that accidents to children should be reported immediately not only to the Committee but also to the police (following an accident in which a child at the JHFG had been involved).

4.30.5 August 1955. A proposal was approved allowing girls to live in the Home for a year after taking up employment.

4.30.6 August 1955. Matron at the JHFG to attend a refresher course in England to assist her in dealing with the older girls.

<u>Governance 1945–1959 (Jersey Home for Boys; Jersey Home for Girls)</u>

4.31 The legislation in force over this period vested authority in the Committee for not only determining who should be placed in the Home (aside from those sent to the Home by order of the Royal Court) but also the power to refuse to

accept a child, as well the power to remove a child.[34] Only the Committee had the right to approve or refuse admission.

4.32 When evaluating the governance of the Homes over this period, we paid particular attention to extracts from the minutes that were read into the record.[35] In addition to the specific matters relating to the individual homes set out above, we note the following general issues:

4.32.1 June 1946. Constables were asked to apply to the Education Office for all admissions to the Homes.

4.32.2 February 1954. A Children's Advisory Committee dealt with matters relating to children who had been boarded out, and had then been removed and placed in a Home without any psychological impact. The Public Instruction Committee decided against giving this Committee any formal recognition.

4.32.3 March 1956. The Director of Education was instructed to arrange for more complete records to be kept of each child, as in many cases, children at the Homes appeared to be unaware of the existence of their relatives.

Findings: Jersey Home for Girls and Jersey Home for Boys

4.33 The concern of JHFB staff in 1954 regarding a senior staff member's use of the strap and the consequent resignation of staff at the Home is indicative of some awareness of boundaries and minimum standards in management.

4.34 In terms of rules and discipline, JHFB and JHFG were still run on rules drafted in 1924. In 1951, the UK had introduced legislation regulating the use of corporal punishment in children's homes (it had done so in 1933 for Approved Schools) and, yet no equivalent legislation existed in Jersey, meaning that there was no prohibition on things like caning children in front of other children, corporal punishment of girls over the age of ten, or restricting corporal punishment of under 10s to smacking of hands with bare hands.

[34] Public Instruction Committee Act 1953, LG000181

[35] Day 144

Various records from the punishment books refer to strappings and public punishment. In this regard, we find that the organisation and oversight of the Homes was deficient.

4.35 We considered evidence about bullying and boy-on-boy sexual abuse, both of which are substantiated by records in the punishment books. Other than corporal punishment, we saw no evidence of these issues being tackled. Although in hindsight we consider this to have been inadequate, the approach taken is likely to have been in accordance with the standards of the time.

4.36 On the basis of the evidence, we consider that there were inadequate numbers of staff at the Homes during the relevant period, given the large number of children residing at each of them. More generally, these had become the type of institutions that had been deprecated in the Curtis Report, which was published in 1946.

4.37 We do not have sufficient evidence to come to a finding about the recruitment of staff at these Homes or the adequacy of training. It would appear that qualifications or training were not a requirement when being recruited to a senior role at the Homes.

4.38 The culture of the Homes changed over the relevant period. However, on the basis of evidence from former residents and from contemporaneous records, the regimes remained harsh and the Homes were strictly regimented. The fact that they were in effect combined Approved Schools and children's homes may explain the harsh regimes, but does not, in our view, diminish the suffering of the children who were sent to these Homes.

4.39 Governance of the Homes as discharged by the Public Instruction Committee was largely adequate. The minutes of the monthly meetings suggest close scrutiny of some aspects of the Homes and the welfare of the children. We note that there is no record of the Committee having inspected the punishment books kept at JHFB.

Westaway Crèche

4.40 Because the Inquiry received no allegations of abuse in relation to Westaway Crèche (as might be expected given the young age of residents), we have not considered its management, organisation, culture and governance. The type and nature of the Crèche are set out in Chapter 3.

Sacré Coeur

4.41 The States of Jersey had no supervisory responsibility for Sacré Coeur until the passing of the *Children (Jersey) Law 1969*. The Education Committee then became responsible for inspecting and registering Sacré Coeur as a "Voluntary Home". Prior to this, there appears to have been some periodic involvement by Children's Services, as can be seen by a report to the Children's Sub-Committee in August 1964 in which the Children's Officer stated that the children there were *"generally well cared for, although there were various questions of emotional deprivation that she would like to see rectified".*[36]

4.42 By 1971, the Children's Officer, Patricia Thornton, *"was concerned about the standard of childcare offered in this establishment and is particularly keen that, as part of our overall inspections, the Home Office should be introduced to the convent".*[37] The Children's Sub-Committee deferred re-registration until a report had been received following a visit by members.[38]

4.43 Only two children in care were resident at this point; other residents, it appears, were all placed privately.[39] The Education Committee paid a boarding out allowance to voluntary establishments such as Sacré Coeur for placement of children in care.[40]

4.44 The Inquiry has very little documentary evidence relating to Sacré Coeur. It seems that some children were abandoned there, given up by parents or relatives, or placed there temporarily by private arrangement. The accounts of

[36] WD005586
[37] WD005590
[38] WD005590
[39] WD005587
[40] WD004989/2

those placed there as children vary. Some suggest that the convent was strict, impoverished, behind the times and that children were employed to work. Others provide positive accounts of their time at the convent.

4.45 WN19's account suggests that there was no States' involvement with her family whose alcoholic father mistreated her and her siblings.[41] She said that many families did what her family did and put their children in homes for short periods. WN19 was resident at Sacré Coeur for short periods in 1958 and 1959. This may suggest that, in the late 1950s, unregistered private arrangements placing children in voluntary homes was accepted in Jersey, at least in certain sections of the community.

4.46 WN19 described the daily routine at the home as " … *Church, breakfast, school and then working".*[42] The children would all be put to work; whether that be in the laundry room, or sewing/knitting duty or out in the grounds. Similar accounts are provided by other witnesses[43] such as WN240. She describes the Home being run by the nuns but with menial work carried out by the children and the menageres (former residents of the orphanage). She also told the Inquiry that there was no time to play:[44] "*you looked after the children, you washed, learn to cook and do housework. So, there was not really that much playing involved, but again that's the way it was in them days".* She said that corporal punishment was commonplace at home and at school: "*you did something wrong, you got the cane …. that's the way it was".*[45] She recalled that boys and girls were segregated at the orphanage and that the girls slept in one very large dormitory, with the babies sleeping separately.[46]

4.47 WN19 confirmed that there was a knitting factory in the grounds[47] and that the older girls worked in the factory. The younger girls (some as young as seven)

[41] WS000008
[42] WS000008/3
[43] WS000271/3
[44] Day 12/9
[45] Day 12/15
[46] Day 12/6/24
[47] Summerland factory

worked in the classrooms at the home sewing labels on the knitwear.[48] Children were also sent into St Helier to sell flowers to make money.

4.48 WN240 worked in the factory, as a nine- or 10-year-old, on a Saturday (when it was closed) cleaning the fluff from under the machines. She said that work on sewing labels continued in the holidays.[49]

4.49 There is conflicting evidence on this point but the weight of the evidence suggests that the working language of the Home was French. The children had to speak in French at least when communicating with the nuns. A significant consequence of this was that children could make themselves understood on a basic level but were not able, or invited, to express their feelings.[50]

4.50 WN19 described a culture of silence with children not being able to speak in the dormitory, in the dining room or while working.[51] According to WN240, the enforced silence meant that the children did not really get to know each other.[52]

4.51 The accounts of former residents who allege that they were physically and/or sexually abused are summarised briefly in Appendix 2. We also heard evidence about extreme punishment for bedwetting from WN152, WN150 and WN240. The Inquiry also heard positive evidence from various witnesses: WN237, WN315, WN327, WN337, and Pat Lucas.

Findings: Sacré Coeur

4.52 There is insufficient evidence to come to an overall view about the adequacy of the organisation, management and governance of Sacré Coeur. Most of the evidence is from former residents and does not provide much insight into the management and organisation of the Orphanage. However, we note the concerns voiced by the Children's Officer in 1964 and 1971 about "*emotional deprivation*" and the standards of child care respectively.

[48] Day 12/11
[49] WS000271/17
[50] WN240; Day 39/35
[51] Day 12/18
[52] Day 39/64

4.53 With regard to the culture of the Orphanage, the picture of life at Sacré Coeur is mixed. The majority of witnesses describe a harsh and strict regime with frequent physical punishments for breaking rules. The orphanage is notable however for the number of witnesses who say that they had a happy and fulfilling childhood there. Their view was that the regime, while strict, was not abusive. It was simply part of life in an orphanage that had very little money. In our view, the preponderance of the evidence does justify the conclusion that the regime was abusive in that the emphasis was on discipline rather than on nurture. This is so even taking into account the standards of the time.

4.54 The industrial model of the Summerland factory existed elsewhere but went on far longer in Jersey, with young children assisting in the work of the factory.

4.55 With regard to governance, while we accept that Sacré Coeur did not come under the supervision of the States of Jersey until 1969/1970, the fact is that it was a well-known institution on the island in whose care were a number of vulnerable children and, as such, should have been of interest and concern to the public authority. It was not adequate that as of May 1958, there were 66 children resident at the Orphanage without any public supervision or inspection. We have only seen evidence of one visit by the Children's Officer, in 1964. We consider that the States of Jersey should have taken greater responsibility for ensuring that these children were adequately cared for. Given that it had such powers in this period with regard to children who were privately fostered, we do not accept that it was powerless in relation to the large number of children admitted to the Orphanage.

4.56 From 1969/1970, we consider that the States of Jersey's oversight of the Orphanage, as a Voluntary Home for which it had supervisory responsibility, was adequate.

Haut de la Garenne (1959–1969)

History

4.57 As part of Operation Rectangle, Police Intelligence Analyst Peter Wall summarised the allegations emanating from Haut de la Garenne. Some 250

allegations were made by former residents against 106 individuals – the incidents alleged to have taken place at the Home or associated locations used by staff and children. Of those, 48% involved an element of sexual offences. 82% related to the period from 1960 to 1980, with the peak in the period from 1966 to 1970. The allegations dropped sharply for the period after 1980.

4.58 Three of those accused held the post of Superintendent of the Home, namely Colin Tilbrook, WN532 and Jim Thomson. If one includes allegations of physical assault by Mario Lundy while at HDLG, then the Home was run and managed by those accused of abuse for over 20 years of its 27 years of operation. Other individuals accused of serious sexual and physical abuse occupied senior management positions within the Home.

The legislative and regulatory context

4.59 During this period, admissions to HDLG were governed by:

4.59.1 the *1935 Loi Appliquant à cette Ile certaines des dispositions de L'Acte de Parlement intitulé "Children and Young Persons Act, 1933*";

4.59.2 the *1947 Loi modifiant la loi (1935) appliquant a cetter Ile certaines des dispositions de l'acte de parlement inititule "Children and Young Persons Act 1933"* (the Public Instruction Committee being given paternal rights over children placed in institutions);

4.59.3 the *Public Instruction Committee Act 1955* (confirming among other powers, the right of the Committee to refuse to receive a child into care and the right to require the Constable to take over the care of a child whose conduct was considered "prejudicial to the other children in the Home").

4.60 Other legislation regulated the levels of financial maintenance to be provided to children in the Home.[53]

[53] Loi pour modifier la loi (1935) appliquant à cetter ile certaines des dispositions de l'acte de parlement intitulé 'Children and Young Persons Act 1933', 1958.

4.61 Where, rarely in this period, a statutory basis was documented for taking a child into the care of the Education Committee, *Article 7* (Approved School alternative) or *Article 8* (in need of care and control) of the *1935 Loi* would be recorded as having been relied on.[54]

4.62 In the UK, the *Children and Young Persons Act 1963* required local authorities to provide guidance and assistance promoting the welfare of children "*by diminishing the need to receive children into or keep then in care*".[55] The *Approved School Rules 1933* as amended by the *Approved School Rules 1949*[56] remained in force throughout this period, only to be replaced by the *Approved School Rules 1970*[57] which reflected the abolition of approved schools in the UK and the introduction of community homes with education. The *Administration of Children's Homes Regulations 1951* also remained in force in the UK throughout this period, governing local authority homes as well as voluntary homes.

4.63 Two Home Office reports came out during this period concerning the management of approved of schools. The first – "*Disturbances at the Carlton Approved School: Report of Inquiry by Victor Durand QC 1960"*[58] – followed disruption over several days by a large group of boys (out of 96 who were resident in the school at the time). In evidence, 33 boys made allegations of ill treatment by staff. Among other recommendations the report concluded that the use of force by the headmaster as a means of control was to stop and that irregular punishments should be prohibited. It was suggested that a culture where boys should be able to see managers and the headmaster of a school personally should be encouraged. One recommendation was that "*general consideration should be given to the desirability of having one or two secure rooms in schools training boys of senior age for the separation (for quite short*

[54] WD001234
[55] See LG000076, Section 1
[56] See LG000096
[57] See LG000097
[58] See GD000017

periods) of boys who suddenly become very difficult and intractable for what appears to be only a transient phase of conduct".[59]

4.64 The second – "*Administration of Punishment at Court Lees Approved School: Report of Inquiry by Edward Gibbens QC"*[60] – came out in 1967. The Report looked at specific complaints of excessive corporal punishment: its findings were confined only to whether or not the complaints were made out. Among other findings it concluded that on occasion the headmaster had "*caned boys with excessive severity".* The report followed an anonymous letter sent to the *Daily Mail* by a member of staff complaining about the use of corporal punishment. The school was subsequently closed down. In a memo to a member of staff at HDLG in the wake of the report warning the staff member about striking a child, Colin Tilbrook refers in passing to the closure of Court Lees (see below).

4.65 In their report to the Inquiry[61] Professors Bullock and Parker noted that, as at 1960:

> *"… the proportion of* [child care] *staff who were qualified remained relatively low (in 1960 28% of CCOs were trained) and was lower still for residential staff as at first their training was usually the responsibility of the local authority".*[62]

4.66 Their report noted over this period that:

> *"The history of the approved schools provides a good example of a sea change in the influences on policy and practice. There was a concern about rising costs and a generally anti-institutional ethos across the developed world and for the first time the adverse effects of institutionalisation (institutional neurosis) were being charted. This had been suspected by the Curtis Committee who noted that many of the children in the places they visited were 'touch hungry' and 'desperate for attention."*[63]

[59] GD000017, p.61
[60] GD000014
[61] EE000136
[62] EE000136/9, paragraph 28
[63] EE000136/16, paragraph 47

Organisation, management and structure

4.67 As noted above, HDLG was formed by the amalgamation of the JHFB and the JHFG (and subsequently the Westaway Crèche).

4.68 Each admission to the Home was recorded on a form which had to be signed by the relevant Connétable "*concerned*" who was responsible for the financial maintenance of the child during his or her time in the Home. WN515 remembered that children were brought to the Home by social workers and that their admission was recorded in an admission book.[64] WN514 said that generally there were "*good records*" kept on the children. HDLG produced its own single-sided admission pro forma record and discharge record which were stored in the child's file.[65] Within 24 hours of arrival, the child had to be seen by the GP and a health form completed.[66]

4.69 One account in 1960 records a CCO collecting a child from his home and taking him to the Town Hall "*for the necessary medical examination, before his admission to Haut de la Garenne".*[67]

4.70 The Children's Officer's Annual Reports recorded residency figures. The number of boys during this period significantly outnumbered the number of girls. Limited statistics are available relating to admissions by age.

4.71 Descriptions of holidays feature regularly in the annual reports. In 1959, children were camping by the river Wye, youth hostelling in Wales, camping in Jersey and visiting Lancashire. In 1960, 15 children did an exchange with 15 children from Fields Cottage Homes in Birmingham; others went camping in Jersey and youth hostelling in England. In 1962, children went to Spain and to Wales and in 1963 to London and to Brittany. The 1964 Report refers to children belonging to "*many and varied youth organisations in the island*".[68]

[64] WD006925/2
[65] WD006713
[66] WN866; WD001837
[67] WD000634
[68] EE000060/4

4.72 In 1965, there were visits to Ireland and Sark for the children. An adventure playground was built at HDLG by the staff in 1967; the following year, a swimming pool and paddling pool were completed at the Home.

4.73 WN615 [1966–1970] recalled that part of the daily routine was to watch the news in the juniors' playroom and "*after that then they could play pool or table tennis … In the summer, they would go to the beach".* WN615 would take some of the girls to her flat in HDLG to listen to music and have coffee.[69] Watching the 6 o'clock news was, as WN202 remembered, "*one of Mr Tilbrook's rules".*[70] Children were allowed pets. Children played outside in the grounds. They had their own gardens. A film would be screened weekly.

Visitors

4.74 In 1961, the Education Committee accepted a recommendation made by Colin Tilbrook, the Superintendent from 1960 to 1973, that children at the Home should have more outside contact. He suggested that visiting day be abolished and that visitors should be encouraged to visit regularly and more frequently. It was intended that the date of each visit, the name(s) of the child(ren) and the names of the visitors should be recorded,[71] although the entries available to the Inquiry appeared sometimes simply to record where the child had gone. Based on an analysis conducted by the Police of the records in relation to the case of WN264, most of the visits occurred on Saturdays.

4.75 WN264 had contact with 11 children over a 3½ year period.[72] In his evidence to the Inquiry WN264 described the basis on which he became a volunteer visitor to HDLG in the early 1960s. He thought that he had met Colin Tilbrook in a hotel bar where they struck up what he described as "*an acquaintance".* He and his wife were invited to dinner at HDLG. He volunteered to take children out as *"a nice thing to do".* He told the police, when interviewed in April 2004, that there was no vetting procedure. The visiting process was

[69] WD001881/5

[70] WS000073/2

[71] See for instance WD001870, WD001822, WD001572

[72] WD001184

informal; he thought that staff would know in advance of his visit. He was not required to sign a register and he would take children to the beach or to the cinema at his expense. He described the system as being "*as relaxed as can be".*

4.76 Margaret Davies, the Matron from 1961 to 1973, said, in her statement to the Inquiry,[73] that there were no formal checks in place for visitors taking children out, "*but we got to know the people who took the children out by chatting to them when they arrived or left so we were comfortable to allow them to go. Children would not go out with strangers".*[74] She says that most of the people who came knew the children and that "*many were the parents of school friends".* Ms Davies was keen to encourage fostering and saw the visits as a means of furthering fostering opportunities for children in the Home.[75]

4.77 In 1962, the Children's Officer, Patricia Thornton, recorded a meeting with an individual at Jersey Airport who knew one of two brothers at the Home as a boy "*used to spend nearly all his free time after school at the Airport*". She noted that the adult, "*seems a very nice young man … [he] said he would very much like to take an interest in both boys and he thought his family would too".* The vetting appears to have consisted of Patricia Thornton visiting the volunteer's mother at the family home, the mother telling her that "*she would be very pleased for [her son] to have the boys out and she will invite them back to the farm. I arranged that she should contact Mr Tilbrook … I do feel that this would be a good contact for* [the boys]*".*[76]

4.78 The informal approach described by witnesses is at odds with the approach advocated in an undated memo from Colin Tilbrook addressed to all Houseparents: *"Children are not allowed out of these premises unless my agreement has FIRST been obtained. Our legal responsibilities for these children are very clearly defined and a considerable amount of 'vetting' is normally undertaken before any child is allowed to visit relatives, friends or*

[73] WS000606/16
[74] WS000606/16, paragraph 63
[75] WS000606/16
[76] WD000871

acquaintances, even for short periods."[77] There is little evidence before the Inquiry of what the "*considerable amount of vetting*" amounted to or whether it was in fact carried out in practice. However, in one example available to the Inquiry in 1968, a couple wishing to befriend a child were required to give two references, which were checked, and their house was to be visited. Colin Tilbrook also met with the couple and upon noting the male's aggression towards his own child, they discussed alternatives to using corporal punishment. The couple were encouraged to take out WN174.[78]

Staff: recruitment and training

4.79 Colin Tilbrook and his wife Margaret Davies were recruited as Superintendent and Matron in 1961. They had come from working in the UK at the Church of England Children's Society Reception Centre. They had also worked in a boy's home in Scarborough and at Barnardo's Cottage Homes. In a 1961 report to the Children's Sub-Committee Colin Tilbrook noted that aside from himself, the Matron and one Housemother, "*no other member of staff has been specially trained for residential care work".*[79] Both Margaret Davies and Colin Tilbrook had obtained the Home Office Certificate in residential child care. In the same year an assistant Housefather was appointed who had undergone the Home Office Residential Child Care course.[80]

4.80 In her statement to the Inquiry Margaret Davies recalled:

> *"Unfortunately, the Houseparents tended to drift into the job, usually without training or formal qualifications. As for the other staff, a number of local people worked at the home in the holidays, to get experience but in most cases, we found that they were not suitable."*

4.81 WN930 (1965–1966) remembered a regular turnover of staff, and most, she said, "*could not cope with the oppressive environment in the home".*[81]

4.82 There was evidence available to the Inquiry on the experience of staff recruited in this period. WD0001181 tabulates the previous residential

[77] WD00526/33
[78] WD001269; WD001260
[79] WD006678/234
[80] WD001168
[81] WD006733/4

experience of 40 staff between 1961 and 1967. Of those, 28 had no previous experience of working in residential child care.

4.83 WN515 (Housefather 1967–1974) had worked in industry, volunteered in youth clubs and helped with outdoor pursuits. He had no formal child care qualifications. WN514 (Housemother 1967–1974) had been a clerk and had no professional child care qualifications. Audrey Mills (Houseparent; laundry assistant) was interviewed in 1967 for a post at HDLG by Patricia Thornton, Charles Smith (then Deputy Children's Officer) and Colin Tilbrook. She was 28. She had no formal qualifications – "*no-one at that time really did. I do not even think the housemasters were trained".*[82] She had worked in the Westaway Crèche for two years then privately as a nanny. She remembers there being no formal vetting process when she applied. WN615 (Houseparent 1966–1970) remembers that she was interviewed for the post of Housemother by Mr and Mrs Tilbrook and "*the head of the Children's Office".* She had had no previous child care experience, was first appointed to look after the juniors – "*7 to 10 years of age*" – and within a short time to look after the seniors – "*11 to 14".*[83]

Staff/children ratios: organisation of the residents

4.84 As at 1960, there were a Superintendent and Matron, and a Deputy Superintendent, but only one Housefather. The Housefather was assisted by three assistant Houseparents. Two further Houseparents were recruited during the course of that year. At the time, there were approximately 50 children in residence.[84]

4.85 In 1962, the Children's Sub-Committee considered a "Plan for Haut de la Garenne accommodating all age groups of children and care need". It envisaged dividing the home into seniors, intermediates and juniors providing for 12 children in each group with additional places for remand children. Staff allocations were set out. A married couple was to be in charge of each group.

[82] WS000585/2

[83] WD001881/3

[84] Day 31/13

4.86 Margaret Davies (Matron 1961–1973) describes the distribution of staff allocated to the three groups: "*The Houseparents were married couples and generally the man dealt with the boys and the women dealt with the girls, although that was not always the case."*[85] She described to the SOJP in 2008 that the intention when she and Colin Tilbrook they took over the running of the Home was to "*try and keep children's families together so siblings were kept in the same group allowing them to mix and eat together. The large dormitories were broken up into smaller sub-rooms to give the home a nicer less sterile feel".*[86]

4.87 By 1968, there was concern voiced by staff about the number of children in each group.[87] A member of staff was near to breaking point. Colin Tilbrook wrote to Patricia Thornton: "*This serves to underline my constant criticism about the number of children in each group, and I would urge you to keep this matter constantly under very active review and not allow the numbers in each group to exceed the totals I have advised."*[88]

4.88 A year later, Colin Tilbrook, in a letter to a UK college sending students HDLG, writes: "*We have a large staff of 36 (for 60 children) many of whom hold professional qualifications …"*[89]

4.89 In 1969, a major re-organisation of HDLG was proposed by the Children's Officer, Patricia Thornton, based upon a report prepared by Colin Tilbrook. The proposal was to increase the number of secondary school age children and reduce the number of preschool age children.[90] This foreshadowed a fundamental change in the operation, management and culture of HDLG in the following decade. The main recommendation was for a regrouping of the children:

4.89.1 *"fifteen children of mixed sexes of preschool age;*

[85] WS000606/5, paragraph 21
[86] WD006689/22, paragraph 5
[87] WD006637
[88] WD006637
[89] WD006662
[90] WD005367

4.89.2 *fourteen children of mixed sexes of primary school age in the ratio of five girls to nine boys;*

4.89.3 *twenty-eight children of mixed sexes of secondary school age in the ratio of ten girls to eighteen boys".*

4.90 The change in composition of the children in the Home required a change in staffing allocation and ratios. The changes were introduced in 1970.

4.91 By the end of this period and into the start of the next decade, staff were writing to senior management setting out their concerns about the increase in the number of residents:

> "*With fourteen boys and seven girls in the Senior we feel we have reached saturation point and all we can do is to 'contain' them and not give them the help we want to give".*[91] Staff/child ratios appear to have become a more pressing issue in the following decade, as noted in Colin Tilbrook's letter from April 1971 about lack of staff and too many children, "*Overcrowding forces regimentation, blunts the sensibilities and restricts individual freedom."*[92]

Staff: duties/routines

4.92 When providing a reference for Ray Williams in 1970, Colin Tilbrook set out Ray Williams' and WN615's daily duties at the home:

> *"*[they] *have cared for a group of adolescent children of the secondary modern age group. They have always worked a 42-hour week* [and] *have had two consecutive days off each week as well as six weeks' annual leave and have not been involved with domestic work as adequate help of this nature has always been available* [by] *the employment of full time non-residential cooks, seamstresses, laundresses and cleaning staff. Their duties have been arranged so that after calling their group of children at 7.15am having breakfast with them and seeing them off to school at about 8.15am they are then off duty until the children return home from school at about 4.30pm when they remain with them until bedtime at 9.30pm. At weekends the children are called at 8.30am but it is normally possible for the staff to have a morning, afternoon or evening session off during this time. Occasionally [they] may be involved in escorting children to clinics etc during the day".*[93]

[91] WD001214

[92] WD008614

[93] WD001213

4.93 Audrey Mills (1967–1972); Houseparent/laundry assistant) told the Inquiry[94] that her duties at the Home involved looking after children "*seeing that they were clean, well fed and well looked after*" rather than providing emotional support. It was, she commented "*a different era".* Audrey Mills was reassigned to the laundry room after concerns were raised by the Education Committee that as an unmarried mother she should not be working with children.[95] Other members of staff provided evidence of spending a lot of time doing laundry due to a number of children wetting the bed, of writing short handover reports when signing off duty, of getting them up and off to school, of tidying and doing laundry while the children were out, and then of spending the evening doing what the children wanted. One Housemother recalled reading written reports when getting the children up, and recalled little interaction with other groups.[96]

4.94 On taking charge at HDLG, the Tilbrooks changed the layout of the Home and "*ensured that the dining room was altered so that staff could sit and eat with the children".*[97] The system of using "house boys" that had existed in the JHFB was abolished in 1961.

4.95 WN615 remembers that children had to ask permission to go to the toilet, although she disagreed with this. She said that children could not be visited by parents or relatives without permission. Staff had to know where the children were at all times.[98] Children would be supervised when having baths – according to WN515 and WN514, they would do this while standing in the doorway.[99]

4.96 According to WN515, there was a logbook to record issues with the children, and up to 1970, a file appears to have been opened on each child in the Home. There is no evidence available to the Inquiry on whether members of staff would have access to children's files and if so which members of staff

[94] Day 73/8
[95] WS000585/5
[96] WD006741/4, paragraph 17; WD006734/3; WD001881; WD006768
[97] Margaret Davies (née Tilbrook) – WS000572/2
[98] WD001881/5
[99] WD006925

were allowed access nor is it known where the files were kept although the presumption is that they were in the Superintendent's office. From 1970, the system changed from individual to family files.[100] As at 1969, a system was in place for reporting and recording accidents and for notifying the Children's Office.[101]

4.97 One member of staff – the night nurse – was on duty through the night and patrolled the dormitories on an hourly basis. Children were monitored by a system of "speakers" in each dormitory and a receiver in a side room where the night nurse sat. Margaret Davies told the SOJP that the night staff were both male and female, "*however we never employed a non-married male to work in the home*".[102]

4.98 The Superintendent and Matron had overall responsibility for the running of the Home, the training and supervision of staff, and for the recruitment of other staff. The Superintendent would also liaise with the Courts and schools about children, and take an administrative role.[103] His duties are discussed below in greater detail.

Staff: training

4.99 In 1960, George Maggs (the predecessor to Colin Tilbrook) and another member of staff, WN784, attended a refresher course in residential care, run by the Home Office. The 1962 Annual Children Officer's report noted that three members of staff from HDLG had attended the Home Office Refresher Courses for residential child care in England.[104] The 1966 annual report recorded the help given to staff and children by "*the medical officer of Health, the Deputy Medical Officer of Health and the Consultant Psychiatrist at the Child Guidance Clinic. The residential staff much appreciate the regular discussions they have with the Senior Registrar of the Psychiatric Unit".*[105]

[100] WD006923; WD008615
[101] WD002359
[102] WD006689/23
[103] WD006254
[104] EE000058
[105] EE000062/5

4.100 The 1965 Home Office Inspection refers to the Education Committee's policy of "*seconding freely to training courses*" staff at HDLG.[106]

4.101 This policy was still in place four years on. In November 1969 the Children's Sub-Committee recommended that "*residential staff should be granted leave of absence with full salary for the purpose of attending short or long courses whether of initial or supplementary training and that each application should be considered on its merits, depending on the length of time the applicant had been in service and the numbers going forward each year".* This recommendation appears from the records to have been prompted by two members of staff, including WN202, applying for leave of absence on full pay to attend child care courses. It is not clear from the minutes whether WN202 was in fact given leave of absence;[107] her subsequent application form dated 1973 suggests that she was not.[108]

4.102 Audrey Mills could not remember there being any training during her time at HDLG, nor any guidance or manuals provided on her duties. She compared this with the training that she received when she went to work as a Housemother in Tower Hamlets, London, in 1972 and received "… *training on social care, psychology, childcare …*".[109]

4.103 WN515 (1966–1974) told the police that he recalled in-house training while he was at HDLG, which included "*an induction course with somebody from the mainland".*[110]

4.104 WN514 (1966–1974) said that she was trained "on the job" by Colin Tilbrook. There were monthly training meetings with the Superintendent; as well as with trainers from the UK on report writing, child care, rules of the Home and dealing with temper tantrums.[111]

[106] WD006689/13
[107] WD006520
[108] WD006553/2
[109] WS000585/7
[110] WD006923
[111] WD006714/1

Staff: contact with Children's Services: student placements

4.105 There are numerous examples in this period of case conferences and observation conferences taking place at HDLG. These were attended by Children's Services (including the Children's Officer) and staff from the Home (including the Superintendent and Matron).[112] In the conferences both the children's CCOs and the Superintendent would give their reports on the children.[113] Decisions taken on the future of children, including the continued stay at the Home, appear to have been taken collaboratively.[114]

4.106 There appears to have been regular liaison between a child's designated CCO and the Superintendent.[115] The relevant CCO would be copied in on memos between the Superintendent and the Children's Officer concerning the child. It is not possible to conclude from the available records what information the Superintendent was given by the Children's Officer about children placed in the Home. There is a record of Colin Tilbrook asking for the case history on a particular child in advance of a case conference.[116]

4.107 Events affecting children's welfare were not only raised in the monthly Children's Sub-Committee meetings but were also relayed by the Superintendent to the Children's Office in a constant flow of letters and memoranda. There are frequent examples of the Superintendent in close and constant contact with Children's Office, the Superintendent being copied in to the CCO's records as well as into correspondence between the Children's Officer and other agencies relating to the welfare and plans for individual children in the Home.[117] The Superintendent appears also to have been consulted by the Children's Office in planning decisions relating to a child's future,[118] as well as being asked to sort out purely administrative arrangements for different children.[119]

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[112] WD002027; WD001890; WD001625

[113] WD002020

[114] WD001891; WD000870

[115] See, e.g., WD001833

[116] WD001963

[117] WD002017; WD002013; WD002012; WD001752; WD001763; WD001619; WD001777; WD001774

[118] WD001762

[119] WD001746

4.108 There are memos from the Superintendent to the Children's Officer recording children running away;[120] one memo from Colin Tilbrook records that the Children's Office had been informed that a boy's buttocks had been "*badly bruised from caning at school*";[121] there is correspondence between the Superintendent and the Children's Officer about staff leaving the Home.[122]

4.109 Records suggest that there was a practical as well as a formal working relationship between the Children's Officer and the Superintendent[123] and a regular sharing of information relating to the children placed in the home.[124] The Children's Officer appears to have sought the Superintendent's views on individual children.[125] On occasion the relationship appears to have broken down. A letter in 1965 from Colin Tilbrook to Patricia Thornton talks of a "*misunderstanding*" between the CCOs and Haut de la Garenne relating to a Parish Hall Enquiry. The letter also suggests what the Children's Office expected of Colin Tilbrook:

> "*I must confess that I was a little saddened with the last paragraph of your letter. I cannot remember a time when you have not been informed if a child from here needs to attend a Centenier's inquiry. If in future you wish me to notify you of these circumstances when the children are at home it will of course mean that I will have to visit them rather frequently and I cannot always promise that I will have enough time. I will however do what I can to help but I cannot give any guarantee unless I can have considerable help here to give me sufficient opportunity to get round to all the homes.*"[126]

4.110 There is a frankness in the exchange suggesting that Colin Tilbrook was clear in his mind as to the respective roles and responsibilities of those running the Home on the one hand and the Children's Office on the other.

4.111 Staff from Children's Services, including the Children's Officer and Child Care Officers would visit the Home, although the evidence is mixed as to the frequency with which this happened.

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[120] WD001869
[121] WD001509
[122] WD001182
[123] See, e.g., WD001872, WD001577
[124] WD000629, WD000640
[125] WD000643
[126] WD000926

4.112 In 1961, the Children's Sub-Committee agreed that students from Bingley Training College, Yorkshire, be allowed to work during the summer holidays at HDLG.[127] The 1966 Annual report refers to '*one or two sixth formers at Haut de la Garenne"* during school holidays.[128] In 1967, Whitelands College in London arranged for the placement of two of its students: the short letter to Colin Tilbrook provides a brief outline of the two students.[129] In 1967, the Children's Sub-Committee appears to have tightened the procedures as to who could do placements, the "scheme" being limited to "*bona fide students from Teachers' Training colleges, students attending the Home Office Child Care Training Courses*" and sociology undergraduates.[130] In the same year, Colin Tilbrook was welcoming volunteers to work at HDLG.[131] In late 1969, the Children's Sub-Committee agreed that students from Colleges of Education should be permitted to undertake a period of practical training and experience during their vacation in 1970: local students should receive free board and lodging.[132]

4.113 There is no available record of what training or vetting was in place when organising student placements.

<u>Discipline: generally</u>

4.114 Margaret Davies told the SOJP that she and her husband *"established a homely atmosphere in the home which meant that children did not need to be disciplined".* Children who came to the home:

> "*were made to feel part of the family and they would learn good behaviour through being incorporated into the home and made to feel part of something. There were no set rules in the home and children were just brought up subject to the ordinary morals of society such as not to swear or bully others".*[133]

[127] WD006526/380
[128] EE000062/8
[129] WD006663
[130] WD006664
[131] WD006665
[132] WD006520
[133] WS000572/2

4.115 In an undated extract from a "Memo to house-parents",[134] Colin Tilbrook commented:

> *"The criteria to be adopted in dealing with matters of discipline should be 'what would any reasonable person do in the circumstances?' Above all it is ultimately the quality of the relationship between a member of staff and each individual child which will determine how a child behaves in the general sense. A child who feels he is liked whatever the provocation will usually be all right."*[135]

4.116 WN615 (1966–1970) remembers that it was only Colin Tilbrook who gave the punishments: "*I would not question things because he handled it".*[136]

4.117 WN515 (Housefather 1967–1974 remembers that staff were told by Colin Tilbrook not to send children to bed as a punishment and not to withhold food. Colin Tilbrook ran a tight ship: "*over-punishment of the kids was not allowed".* He remembers that "*boundaries were clearly defined".*[137]

4.118 WN514 (Housemother 1967–1974) says that children would be sent to Colin Tilbrook who would then speak to them harshly – there was never any caning.[138]

Discipline: corporal punishment

4.119 In a 1961 report to the Children's Sub- Committee, Colin Tilbrook noted that "*discipline is being well maintained. Corporal punishment was administered on only seventeen occasions during 1961".*[139]

4.120 In October 1962, Patricia Thornton (Children's Officer) suggested to the Children's Sub-Committee that "Rule 8" relating to corporal punishment of the Jersey Home for Boy Rules should be amended, and provided a draft copy, "Appendix D".[140] Although a copy of the Rules was not available to the Inquiry, the Appendix D was put in evidence. These appear to be an amalgamation of

[134] WS000572/2
[135] WD005826
[136] WD001881/5
[137] WD006925
[138] WD006714
[139] WD006678/231
[140] WD001188

the *Administration of Children's Homes Regulations 1951* and the *Approved School Rules 1933*. The proposed rules included the following:

4.120.1 only the Superintendent was authorised to administer corporal punishment, or in certain circumstances the Deputy Superintendent or Children's Officer;

4.120.2 no caning of girls – any corporal punishment must be administered to them by the Matron, or in certain circumstances by the Senior Housemother or Children's Officer;

4.120.3 corporal punishment of boys was limited to *"the caning of the posterior with an approved type of cane, over the boy's ordinary clothing, to the extent of six strokes or less. Blows, cuffs, boxing the ear, striking on any part of the head, shakings or other irregular means of corporal punishment are absolutely prohibited";*

4.120.4 no caning was to be carried out in the presence of another child;

4.120.5 no corporal punishment of any child with a physical or mental disability, without the sanction of the Home's Medical Officer.

4.121 Margaret Davies (Matron 1961–1973) remembers going to "the Committee" when she and her husband first started at HDLG, taking with them the cane and punishment book and telling the Committee "*we would not be using them and handed them over".* Despite the "Appendix D" memo, Margaret Davies states that she was not aware of Colin Tilbrook ever caning children at the Home.[141]

4.122 Set against her recollection, and aside from the extract in the 1961 report (see above), are memos from Colin Tilbrook to the Children's Officer, recording the number of strokes that he had given children on specific days. as well as entries in the punishment books up to 1967. Extracts from the punishment books show that the frequency of caning was reduced and the number of strokes fewer than by comparison with the number and frequency

[141] WS000606/4, paragraph16

administered by Colin Tilbrook's predecessors.[142] Entries include: "*17.1.63 – 1 stroke – persistent misbehaviour when out with Housemother; 29.04.63 – 1 stroke – obscene language; 20.06.63 – 2 strokes – kicking a junior girl; 20.10.63 – 1 stroke – for setting off fireworks in dorm; 27.11.66 – 1 stroke – for persistent bullying; 16.03.67 – 2 strokes – holding and hitting a boy.*"

4.123 Audrey Mills told the Inquiry that "*in terms of general discipline, it was a different period. At that time, if you needed to stop a child doing something quickly, you could tap or slap them on the hand".*[143] She told the Inquiry that she would not have known at the time what was, and what was not, acceptable.

4.124 WN202 (Assistant Housemother from 1966) recalls slapping a child on the back of the legs and being spoken to by the Matron, Margaret Davies and told not to do it again.[144] One memo to the Children's Office records Colin Tilbrook catching two boys at night on a "*stealing spree".* He "*smacked their bottoms and sent them back to bed".*[145]

4.125 In a memo dated 1979, Jim Thomson (then Superintendent at HDLG), when setting out the scope of discipline to be used in HDLG, commented that he did not want to follow what "*Mr Tilbrook did with under 11 year olds … which is to have a complete ban on corporal punishment with that age group".*[146]

4.126 Audrey Mills could not remember this prohibition on corporal punishment and added: "… *if a child was beyond the control of the staff that were looking after them you would tolerate such behaviour. If it got to a point where you knew you could not control them you would say 'Well, you go and see Mr Tilbrook' and he would deal with the issue, or whatever was happening".*[147]

4.127 WN515 (Housefather 1967–1974) told the police that no child was caned while he was there.[148] Another member of staff (1967–1969) remembered that

[142] See WD005828 – 1963, WD005829 – 1966/67
[143] WS000585/3, paragraph 15
[144] WS000073/4
[145] WD000842
[146] WD006415/8
[147] Day 73/10
[148] WD006924

staff were not allowed to smack the children; only the Superintendent in charge could do this, the under-sevens got the slipper and the older children got the cane.[149]

4.128 In a memo to the Children's Office in 1968, Colin Tilbrook recorded his meeting with a couple who were befriending WN174, after the latter's removal from foster care. Colin Tilbrook described the man, who, while "*very pleasant [and] intelligent is also basically very aggressive".* Colin Tilbrook noted that he "*took the opportunity to discuss with them the whole field of corporal punishment. We examined attitudes and reasons and they were open to the suggestion regarding other methods of punishment".* The man having described how he had caned his own child, leaving "*very bad marks on the boy's legs and buttocks*", Colin Tilbrook "*explained my own professional beliefs and have given him a few ideas which I have no doubt he will mull over".* Those beliefs are not set out in the note.[150]

4.129 A memo in 1967 records Colin Tilbrook's concern that WN515 admitted that he had smacked children on summer camp: "*I told* [WN515] *that he must be very careful about this and drew his attention to the recent case of the Approved School being closed".*[151]

Discipline: detention rooms

4.130 In his plans for the Home set out in a paper prepared by Colin Tilbrook for a meeting of the Committee in October 1961, he recommended that rooms be built for use as detention rooms: *"….. it would be a great help to have two detention rooms away from the general life of the Children's Home. This will be used only, we hope, on very rare occasions, but will be useful for the very disturbed older boy or girl, on remand particularly. This is bearing in mind that we must cater for young people up the age of 16".*[152]

[149] WD006723/2

[150] WD001269

[151] WD002019 – the reference to the Approved School being closed is likely to be to Court Lees Approved School into which a report on the use of corporal punishment had just been published – see GD000014

[152] WD001206

4.131 By 1962, the intended use had changed. It was now proposed that the two detention rooms would have: "detachable bars, the rooms could sometimes be used for adolescents staying at the children's home or for a youngster who needed privacy away from the main group".[153] The detention rooms were built following Home Office guidelines and were inspected by the Home Office inspectors in 1965 and 1970.

4.132 Rules for the use of the detention rooms were drawn up at the request of the Children's Sub-Committee in 1966.[154] The rules permitted a child being locked in detention for a continuous period of up to four days, with some exceptions for longer periods. On one reading this could be understood to mean the children could be kept in detention for longer than four days provided they were not locked in continuously. The rules recognised that placement in the detention rooms could follow a court order: "*No child will be permitted to be kept locked in the rooms for a longer continuous period of more than 96 hours (i,e after Court recess on Friday until Monday morning) unless sent here on a Court Order to be so detained because of unruly behaviour or on remand pending transfer to another training establishment and all such children so detained must be seen by the Medical Officer of Health, after 48 hours and subsequently at the Medical Officer of Health's discretion".*

4.133 An analysis of the periods of detention that are recorded suggest that children were in fact kept in detention for longer than four days suggesting that they were not locked in continuously. A record of each use of the detention room would be forwarded to the Children's Office. In turn, the Children's Office would sanction the use of the detention rooms. In one case where WN195 and another boy had been suspended from school, Charles Smith writes to Colin Tilbrook: "*It is realised that this may present difficulty on close supervision and I would agree that when it is not possible for a male member of staff to supervise, both these boys may be detained in the detention rooms."*[155]

[153] WD001174/4
[154] WD0012017
[155] WD000690

4.134 Other rules for the use of the detention rooms included:

4.134.1 only the Superintendent and Matron, or the Deputy Superintendent in their absence, were allowed to place a child in the detention rooms;

4.134.2 any child admitted after 11pm would be placed in the rooms, but with the door unlocked, unless there was police advice to the contrary. The Superintendent would be informed in writing;

4.134.3 all children to be visited by two senior members of staff at least three times a day, and whenever needed by the child;

4.134.4 no other member of staff allowed to contact a child in detention, except with the consent of the Superintendent;

4.134.5 any detained child was the responsibility of the Superintendent and Matron, who were responsible for ensuring proper facilities for washing and recreation.

4.135 Margaret Davies remembers that visits to the children in detention "definitely happened", and were in fact more frequent than the rules required.[156]

4.136 In February 1968, the Children's Sub-Committee asked the Superintendent to prepare a report on the use made of the detention rooms.[157] The list of children's names does not identify those children remanded to Haut de la Garenne under order of the Royal Court. The periods spent in detention range from one night to just under three months. The majority of entries are for between a few days and two to three weeks. It is difficult to assess the significance of the longer periods of detention without knowing which children were on remand.[158]

4.137 Evidence available to the Inquiry shows that the rooms were used not only for remands but also were "*largely used when a child either lost their temper in which case they were used to protect themselves or others or when children*

[156] WS000606/9
[157] WD001205
[158] WD001216

were returned by the police, often to sober up … the children would be locked in".[159] Other staff accounts record the detention rooms being used to calm children down, for their "*own safety and wellbeing*", for a child with a "*really bad temper tantrum*" and for children who had run away or to stop them doing so.[160] Audrey Mils recalled that the Housemaster could arrange for a child to be placed in the detention room, without requiring the Superintendent's approval.[161]

Discipline: bedwetting

4.138 Accounts given by residents suggest that bedwetting was punished. WN494 told the Inquiry "*any boy who wet his bed had to stand outside the office before or after breakfast and was strapped by the Superintendent".*[162] Records were made of bedwetting.[163] It is not clear whether this was to gauge the effectiveness of steps being taken to reduce enuresis.[164] Conversely, Margaret Davies remembers introducing a policy where children were not humiliated for bedwetting: "*I was keen to make sure that we told the children not to worry and we always changed the sheets for them before they returned from school."*[165]

Discipline: home visits and other approaches

4.139 Children had weekend visits home cancelled as a punishment, although parents were still able to visit their children at the Home.[166] In some cases holidays were cancelled. In one of the examples home leave was cancelled for "*being involved in rather a lot of stealing".*[167] Margaret Davies could not remember this happening: "*We would not have tied home leave to behaviour".*[168] This appears to contradict other evidence, such as this extract

[159] Audrey Mills – see above
[160] WD001935; WD00835
[161] WS000606/9; WS000585/4; WD006925; WD001935; WD001928
[162] Day 144/97
[163] WD001538; WD001021
[164] WD002015
[165] WS00606/5, paragraph 22
[166] WD006689/31; WD001574
[167] WD000846
[168] WS00606/9, paragraph 37

from a letter to a father from the Superintendent cancelling the son's home leave:

> *"With your co-operation therefore I should like to stop [WN162] going to you this week-end for I know that this always has a salutary effect on him for he so much enjoys being with you."*[169]

4.140 The decision to stop home leave or to lift the ban appears to have been taken in consultation, on occasions, with parents.[170]

4.141 Other discipline, according to former members of staff, included withholding pocket money, making them clean up rubbish, stopping them from seeing films, and stopping them from going out for the night.[171]

The role and approach of the Superintendent: Colin Tilbrook

4.142 Colin Tilbrook's tenure as Superintendent (1961–1973) had a significant impact on the culture of HDLG. Margaret Davies (Mrs Tilbrook) said that the couple's intention was to try to give the children "*a more normal family environment to grow up in as opposed to a cold orphanage".*[172]

4.143 At the end of his first year at the Home, Colin Tilbrook presented a report in 1961 (referred to above) to the Children's Section of the Education Committee.[173] This report provides an insight into his approach to the management and operation of the Home, as well reflecting his views on residential child care gained from his previous experience. He discussed the Family Group Home (FGH) initiative in the UK and the prevailing view that large institutions were "*appalling places in which to bring up children".* Staffing of FGHs was becoming increasingly difficult. He quoted from a "*Home Office report*" that staff in FGH were "*lonely".* The report set out his aims for HDLG:

> "*1. To create at Haut de la Garenne an atmosphere which will encourage the children to develop all aspects of their varying personalities (i.e. spiritual, emotional, intellectual and physical); 2.To provide a reasonable standard of living such as is to be found in any*

[169] WD002018
[170] WD001650
[171] WD001881/5; WD006714; WD004349
[172] WS000572/2
[173] WD006678

> *middle-class home to enable the children to have full opportunity for enjoying, as is their undisputed right, a happy relaxed and disciplined environment*". He reflected that, "*now that the groups are not too big and are in charge of married couples* [sic] *every child is receiving some mothering."*

4.144 The report referred to the great majority of the children in the Home as having been "*psychologically damaged in some way or another".* He referred to the 8th report of the Children's Department of the Home Office published in 1961 which underlined the need to establish a "*personal but objective relationship with each child, to develop a flexible programme of individual treatment and to give guidance toward the solution of individual problems".* The report closed with Colin Tilbrook adopting an extract from the Home Office review for 1961: "*What matters is that by one means or another the child coming into care should receive by kindly understanding people in a home like atmosphere … fully equipped with a thorough understanding of his personality and needs*".[174]

4.145 In the same year, Colin Tilbrook made a number of recommendations to be implemented at the newly formed HDLG. These concerned diet, leisure, clothing, hygiene as well as "*interpersonal relationships*" and "*emotional outlets".* Under the heading "Emotional Outlets" he noted:

> "*such outlets are available but generally rather restricted. These satisfactions are always difficult in 'institutional' life, although a friendly permissive atmosphere is normally very helpful. Some of the children keep pets. Few of the children are 'mothered' and too much emphasis is directed to group control and care and too little attention paid to the needs of the individual children. Contact with relatives, foster relatives and friends is largely restricted to once a month, although one or two children do go out more frequently. Only the smaller ones have any comfort at bed time. Recommendations and suggestions: (8a) As the staff learn to relate more easily and freely with individual children, many of the limitations will disappear".*[175]

4.146 Colin Tilbrook's recommendations appear to reflect an apparent understanding and anticipation of the children's needs and the staffing challenges in the Home.[176] He promoted the value of siblings maintaining contact wherever possible. In a memo eight years later, in 1969, he noted to

[174] WD006678/235

[175] WD005820

[176] WD005820

staff that six to nine-year-olds *"… need a great deal of 'loving' still and bath-times are often a good opportunity to create an atmosphere of affection, regard and kindness. All the time they are in big groups at school and here – and it cannot be much fun for them".*[177]

4.147 In 1969, he wrote to the Children's Officer (Patricia Thornton) to complain about the strains on staffing:

> "*everybody here is undergoing considerable strain because of the excessive number of children we are caring for … I would now confirm that it is necessary indeed essential, to bring the staffing up to the strength agreed by Committee and I would hope that the Committee would not reverse its decision of 3/4 years ago".*[178]

4.148 Colin Tilbrook foresaw the challenges posed by an increase in adolescent intake and the need for "*a wide, experienced and informed knowledge of all of the new problems"* the intake would require. He set out in detail the new staffing rotas and accommodation needed to address these issues, "*In the interests of good child care and to minimise the friction between staff and children it is essential to separate these children into three groups".* He advocated the continued employment of married couples – "*I have repeatedly expressed that the continued employment of married couples to care for small groups of older children appears to be in their best interests".*[179]

4.149 Elsewhere and seemingly throughout his time as Superintendent, Colin Tilbrook is seen to be forceful in his convictions and views. In 1966, he sought to appoint a single unmarried parent to the post of Housemother. The potential appointment was controversial – although recommended by the Children's Sub-Committee it was turned down by the Education Committee who then issued a statement explaining their position. The statement included a reference to the Superintendent having gone ahead and offered the post notwithstanding that the Education Committee had had yet to make a decision.[180]

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[177] WD008618
[178] WD008620
[179] WD005367
[180] WD006910

4.150 In another instance, in a letter to the Solicitor General seeking to justify his stance defending a boy at Haut de la Garenne against whom an Approved School order had been made, Colin Tilbrook criticises the lack of support from the Education Committee for "*such little loyalty*" towards him (although supported by Patricia Thornton).[181]

4.151 As noted above, as part of his role in the running of the Home Colin Tilbrook would attend case and observation and assessment conferences on individual children in the Home that would take place at HDLG. He would provide the Superintendent's report, a sample of which the Inquiry received in evidence. The reports might be regarded as detailed and informative[182] and include references to the emotions and feelings of the child under review, to their need for affection, to emotional deprivation, rejection and vulnerability. He promoted the value in siblings maintaining contact wherever possible: writing to a CCO in 1962: "*I am sure that, with your sympathetic understanding of children you will agree that we ought to do all in our power to keep these children in contact with each other so that in later life should they need it, they will have each other for support. It is so easy for children to grow away from each other*."[183]

4.152 In a letter dated 1968, from the headmaster of St Martin's School (the primary school attended by children from the Home), he sets out his concerns to Colin Tilbrook about one child, referring in passing to "*what I know from experience to be the loving care at Haut de la Garenne".*[184] Letters record Colin Tilbrook maintaining close contact with schools attended by the children at Haut de la Garenne, attending meetings at the schools on their behalf and notifying the Headteachers of any issues in relation to the children from the Home.[185]

4.153 There are numerous examples of Colin Tilbrook speaking directly with the children and getting their views on particular issues and noting their concerns or recording conversations between himself and individual children, explaining

[181] WD001514

[182] See, e.g., WD002020, WD001729, WD001749, WD001551; WD001418

[183] WD000872

[184] WD001007

[185] E.g. WD000867

their behaviour.[186] Other records show him defending and supporting children at the Home. When replying to a letter of complaint about WN123 from the Headmistress of St Helier's Girls' School, he asked the school to bear with WN123: "*From time to time we are bound to have difficulties with the occasional girl and I hope that between us we will always be able to help the girls to a better understanding. In [WN123's] case we of course very much in loco parentis for she has nobody else to whom she can turn and she does therefore need more than the ordinary degree of parental care from us and with her as with any other child we will continue to take the same interest in her as any normal parent would be expected to do."*[187] As Superintendent, he would receive psychiatric reports on children in the Home.[188] He would write reports to the Constable on children placed at the Home.[189]

4.154 Home Office Inspector A.J.N. Southwell spent "*almost two days*" at HDLG in 1964.[190] The Inspector found the regime to be "*enlightened*", commenting that it was "*forward looking in that it aims consciously and consistently at rehabilitation. It seeks to restore the fabric of each child's individual and social life, not merely to inculcate unreasoning obedience".* The Inspector recognised the physical institutional drawbacks with HDLG, which he felt were overcome by "*imaginative*" and less "*authoritarian*" direction.

4.155 WN866 (a senior staff member) considered Colin Tilbrook and Margaret Davies to have been extremely dedicated and professional.[191] In an unsolicited newspaper interview in 2008, WN491 maintained that HDLG *"went wrong"* after Colin Tilbrook left. WN515 (Housefather 1967–1974) told the police that after Colin Tilbrook left, *"staff morale collapsed"*.[192]

[186] WD001550
[187] WD001878
[188] WD001973
[189] WD000925
[190] WD006689/8–15
[191] WS006019
[192] WD006925/2

Governance

4.156 Through this period, Patricia Thornton was Children's Officer. Records and reports throughout this period (referred to in this section) suggest that she was a committed and dedicated. She appears to have maintained close oversight of HDLG. The Home featured in each of her "Annual Reports" from 1959 to 1968. She appears to have had a good professional relationship with Colin Tilbrook and maintained regular contact with him, the children at Haut de la Garenne and their families. She was involved, with Colin Tilbrook, in reorganising HDLG "*in the interests of good childcare and to minimise the friction between staff and children".*[193]

4.157 The Children's Sub-Committee, was set up, it appears, in 1960. It met regularly, presided over by members of the Education Committee. It would meet at HDLG. The meetings were attended by Patricia Thornton, Colin Tilbrook and Margaret Davies. Colin Tilbrook provided a report at each meeting covering topics such as numbers in the Home, admissions and discharges in the previous month, activities and staff issues. Under "Admissions" brief details would be given of children placed at the Home and under "Discharges", the same would be recorded in relation to children leaving the Home. The Committee reported back to the Education Committee with recommendations and that Committee made final decisions on appointment, recruitment, discharge of children and financial support.[194]

4.158 The Education Committee had overall oversight of the Home, delegating to its Children's Sub-Committee responsibility for overseeing the day-to-day running of States' run children's homes. From witness evidence to the Inquiry it appears that the Children's Sub-Committee could only make recommendations and were not able to take decisions.

4.159 Although only one example, its views on governance of the Home in this period may be reflected in the Committee's decision in November 1966 not to confirm the recommendation of the Children's Sub-Committee to appoint an

[193] WD005367

[194] E.g. WD001169

unmarried mother to the post of Housemother at the Home. That decision had attracted adverse criticism in the *Jersey Evening Post* (JEP). Colin Tilbrook had offered the post notwithstanding that the Education Committee had yet to make a decision.[195] The then-President of the Education Committee issued a statement[196] explaining the Committee's rationale, which in turn reflected its approach and understanding of the Home. The members' first responsibility was to "*the children in their care*": "*the post of Housemother or Housefather calls for the highest vocational standards and example. The ideal at HDLG is to provide the closest equivalent conditions to those of parents and children in normal homes. The work of the Houseparents calls for the highest possible standards and people who undertake this work should, as far as possible, be themselves devoid of personal stress, strains and tensions in order to do justice to this demanding work amongst emotionally disturbed children …*".

4.160 Colin Tilbrook was forced to resign in 1973, after Margaret Davies had resigned earlier in that year. Although the reason why he was asked to resign is not set out in the Education Committee minutes it may be that his position was no longer tenable. The roles of Superintendent and Matron was seen as best undertaken by a married couple; the Tilbrooks were living apart by this date.

Findings: Haut de La Garenne (1959–1969)

4.161 *Vetting* – At the start of this period, there was an informal system of vetting of visitors at HDLG in relation to both those who came to the Home and those who took children out. This appears to have become more structured towards the end of the decade. While the standards applied today would not tolerate such informality, there is nothing to suggest that the approach taken was less than adequate by the standards that then applied, however informal.

4.162 *Staff recruitment and training* – The training and experience of Colin Tilbrook and the Matron when they took up their appointment to run the Home appears to have been adequate: they had had sustained experience of working in

[195] WD006910
[196] WD006910

children's homes in the UK and held the appropriate qualifications. The evidence we have heard suggests that levels of experience and training of staff recruited to the Home were inconsistent and arbitrary.

4.163 *Training* -–Training and development of residential staff appears to have been again inconsistent and haphazard, notwithstanding that the value of training was recognised and encouraged. On the limited evidence we have seen, it seems that training was not sufficiently, if at all, financially supported by the Education Committee during this period. We find that this aspect of the management of the Home was inadequate.

4.164 *Discipline: corporal punishment* – On paper, Colin Tilbrook and the Matron promoted an apparently enlightened approach to discipline; in practice, and in spite of statements to the contrary, we note that Colin Tilbrook did administer corporal punishment throughout the decade. There is evidence that suggests no corporal punishment was administered to children under 11. The use of corporal punishment would have been in line with practice adopted elsewhere at the time. As Audrey Mills told the Inquiry: "*in terms of general discipline it was a different period".* The Inquiry heard a number of accounts from former residents during this period which alleged the excessive use of corporal punishment – whether by its frequency or its severity.

4.165 *Use of detention rooms* – We note that in the Home Office inspector's report in 1970 the fact of and use of the detention or separation rooms were not in themselves deprecated by the Inspectors. We recognise too that one of the Home's functions in this decade was as a remand facility for children aged 15 and under. We note that, in 1966, rules were in place for the use of the detention rooms. The Children's Sub-Committee, in requiring the Superintendent to provide a report in 1968, appear to have recognised their responsibility in overseeing the use of the rooms. We are not able to, nor required under the Terms of Reference, to reach a conclusion as to whether the use of the rooms was during this period illegal: the figures compiled for the Committee did not identify whether the longer periods related to children on remand, nor whether these were continuous periods. We question whether it was appropriate even in this era to have used the rooms as a means of

calming children down. As a means of managing difficult behaviour, in this era, we also question whether the use of the rooms was an adequate approach.

4.166 *The role of the Superintendent: Colin Tilbrook* – The personality of the incumbent Superintendent over this and the next decade inevitably in our view dictated the culture and approach of the Home. We find that Colin Tilbrook did have a significant impact on the culture of the Home during his tenure. He sought to introduce changes to the staffing structure and the configuration of grouping of children. The picture that emerges to us is of a forceful and dominant personality. Unlike his later successor, Jim Thomson – he appears never to have questioned the continued existence of HDLG, nor to have had his management of the Home called into doubt. We note that his immediate successor – WN715 – thought the Home was 30 years behind when he took over in 1973 and needed a completely new approach. It appears to have become isolated and out of touch with residential care practice by the turn of the decade.

4.167 *Governance* – We are critical of the lack of any strategic vision for the continued use of the Home by the end of the decade.

Haut de la Garenne (1970–1986)

Organisation, management and culture

The legislative and regulatory context

4.168 The *Children (Jersey) Law 1969* replaced the *1935 Loi*, providing a new statutory basis for taking children into care. Under *Article 26*, a child under the age of 17 in custody could be remanded to HDLG. As such, was designated a remand centre in the island for a child under the age of 17. Under *Article 28*, the Court could send a child to an Approved School or place him in the care of a "fit person" (*Article 31* designated the Education Committee as a "*fit person*") where the child needed care, protection or control. In practice this amounted to a court order requiring the child whose behaviour was considered to be "out of control" to be taken into care. The Article enabled a Centenier to hold a child in custody at HDLG pending the issue of a warrant.

4.169 By far the most frequent provision used was *Article 82*. Under *Article 82*, the Education Committee could receive a child into care whose parents were unable to look after them and where it was in the interests of the welfare of the child to do so. Parents could at any time apply to take over the care of the child provided the Committee considered it "*consistent with the welfare of the child*". *Article 83* gave the Committee the option to take on parental rights in the circumstances set out under the Law and provided the Committee had obtained a court order. WN7 told the Inquiry that *Article 82* also covered voluntary admissions into care.[197]

Reception, admission and category of child

4.170 WN668 (1974–1976) recalled that all children came to HDLG via the Children's Office and that each had an allocated CCO who liaised with the Home, the parents, the schools and, where applicable, the police. The majority were, according to her: *"underachievers with short attention span and very institutionalised … without exception all of these children had suffered emotional deprivation and had no experience of normal family life. Many were streetwise at an early age, being devious and proficient liars".* She said that the increased admission of children referred by the Courts and the Police had a *"very adverse effect"* on the resident children, some of whom became caught up in difficult behaviour. She reflected that this changed "*the whole ambiance of the home".* The care staff found the change "particularly difficult".[198]

4.171 In a memo to Charles Smith, the Children's Officer, in September 1977, the Superintendent, Jim Thomson, classified the children at the Home into four different types: (i) Children with problems who also have problem parents; (ii) children with problems; (iii) children with problem parents; (iv) children not in the previous three categories.[199] When invited to comment on this memo, WN570 did not think that HDLG was suited to the needs of children whose parents were incapable for whatever reason of looking after them and had

[197] Day 65/77
[198] WD006724
[199] WD002611

consequently been taken into care but she added "*there was nothing else at the time".*[200] WN7 agreed with Jim Thomson's categorisation and said that whatever the category a child fell into, the very fact of being placed in HDLG would have been difficult for a child.[201]

4.172 In his subsequent "Report for the Eighties", Jim Thomson noted that the Home was unsuitable for the range of tasks it undertook and did not work for certain children, including those without family ties, those in long-term care, those who were "*severely disturbed*" and those regarded as "*delinquent and/or disruptive children".* He thought that the Home did work for others, including those with strong family links where there was a "*clear avenue to a return to the family*" and those "*where the stress of the home situation is so severe that the child is happier in residential care".*[202]

4.173 Ernest Mallett (1970–1974; 1981) worked both at HDLG and at La Preference. He was able to provide a contrast between the two groups of children – those he had looked after in 1981 at HDLG and those he went on to look after at La Preference:

> "*I sometimes felt [the children at Haut de La Garenne] were more disturbed or more abused than the ones that I met when I went to the vegetarian home. They were more – I mean they might have had the same things happen to them, but they were more sort of calm and – where the ones from HDLG were like quite – I do not know. They would sort of – they had been through whatever at home, you know, they had not had an easy time and I think that came out in their behaviour and that as well. They were usually the ones there were problems at school with as well*".[203] In Ernest Mallett's view, Haut de La Garenne was "*an institution where [children] were all just flung in."*[204]

4.174 WN570 says that, by the time she left in 1983, there were only two groups of mixed ages:[205] she did not remember teenage girls as being a "*major problem*" at the Home.[206]

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[200] Day 110/37
[201] Day 65/77
[202] WD006984
[203] Day 81/145
[204] Day 81
[205] Day 110/21
[206] Day 110/18

4.175 Marilyn Carré, who worked as a child care assistant (1977–1988) and a CCO (1988–1990) said that the decision by Children's Services to place a child at HDLG was based on "*where there was space and it was not always necessarily what we would have considered the best place for the child".*[207]

4.176 WN102 (1978 and 1982) first worked in an administrative role at the Home: one of her tasks was to book new children in. They would arrive with a CCO, or member of the family, depending upon individual circumstances. WN102 arranged the medical examination on admission and also on discharge. There was a large ring-bound book that contained all the names of past and present children at the Home; it contained their personal details and dates of admission/discharge. Each new child was placed in one of the four groups (Aviemore, Braintree, Claymore or Dunluce). There "*did not seem to be a system in place for allocations except with the very young children; they were sent to Aviemore".*[208] The Superintendent (Jim Thomson) would take a photograph of each child who was admitted. WN7 remembers that it was the Superintendent who would allocate which group a child would go into on arrival in the home. A member of staff would go the Superintendent's office to be introduced to the child and to be told by the CCO why the child had come into care, "*we would then go back and tell the other members of staff".*[209]

Remand centre

4.177 In 1970, figures were compiled, setting out the number of children on remand or pending a Royal Court appearance. The table set out those for whom the detention room had been used and the number of days of use. In one case a boy was held in detention for 115 days, another 34 days, another 23 and another 21 days.[210]

4.178 In the same year, the Children's Sub-Committee was concerned that in certain cases, detention of children, pending a court appearance, could

[207] Day 81/12
[208] WD006810
[209] Day 66/99
[210] WD001208

amount to unlawful detention.[211] There had also been concern expressed by the Home Office inspectors in 1970 at the attitude of staff to the use of the rooms, although what the attitude had been is not recorded.[212]

4.179 An extract from the minutes of the Education Committee in 1972 records Colin Tilbrook's concern at the influence that those being held on remand in the detention rooms at HDLG charged with drug offences was having on children in the Home, "*there was a limit to the time a child could be held in a detention room and it was not possible to segregate them from others".*[213]

4.180 In August 1972, the Education Committee reviewed the existing law:[214]

> *"The Committee, notwithstanding that under the provisions of Article 15 of the Children (Jersey) Law 1969, that no court should impose imprisonment on a child, decided that in the interests of the other children in the Home, the worst offenders should be admitted to the women's section of the prison. The Committee was of the opinion that the Children's Officer should always be present at a Court hearing and that the place of committal should be discussed with him. The Children's Officer was instructed to discuss this suggestion with the Court. The Committee noted that no provision had been made for girls on remand in the juvenile wing of the new prison and as this provision was considered necessary, it suggested that the matter should be discussed with the Prison Board."*[215]

4.181 Despite the fact that, by 1978, Les Chênes had opened and was being used as the main remand centre, the use of HDLG as a remand centre appears to have been controversial during the course of the decade. In 1973, concern was noted for the morale of staff and children that HDLG should take children committed on remand by the court to the Home. News reports at the time in the JEP recorded the court orders naming HDLG as the remand location – this would quickly become common knowledge in the Home. In 1974, the Jersey Schoolmasters' Association wrote to the Education Committee, expressing concern at the number of juvenile offenders placed at HDLG and

[211] WD002050
[212] WD002592
[213] WD002631
[214] WD006208
[215] WD006208

at what the Association described as "*the possible risk to the other children in the home".*[216]

4.182 In March 1980, the Education Committee discontinued HDLG's designation as a remand centre, as, by then, Les Chênes was fully operational.[217] The Education Committee had noted that HDLG had only been designated as a remand centre on a temporary basis, and had never had satisfactory facilities.[218]

Volunteers and student placements

4.183 Ernest Mallett was a volunteer between 1970 and 1974. He had friends who worked there. He would go up to the Home to meet them and became involved in helping out. There was no interview and no vetting process. It was, he told the Inquiry, based on who he knew and that they knew him: "*Jersey is quite small so you really know everybody there."* There was no signing-in book. He would organise outdoor activities and sports and sometimes read to children in the sitting room.[219]

4.184 Under their tenure, WN532 and WN587 (1974–1976) set up a scheme "*with the Jersey police which involved two young police cadets coming to work in the home for about a week at a time alongside the staff*". They could not remember how many came in all, "*maybe about ten".* Their rationale was that they wanted "*the children to get to know the Police as more than just authority figures and the Police to see the children in a better light".*[220]

4.185 One member of staff (1974–1976) remembers volunteers who would visit the Home, "*a few would come up to socialise with a few of the girls and join in with whatever the children were doing at the time, some were working on the Island and just pop up".*[221] He was only 20 at the time he started at HDLG. The same worker remembers being concerned about a priest who volunteered to

[216] Day 42/5
[217] WD004266
[218] Day 42
[219] Day 81/112
[220] WD006213/12
[221] WD006425

take children camping: "*he turned up without appointment or identification … I was immediately concerned that the children were too young and he was unknown".* He went to a senior member of staff and "*we stopped this".* He thinks the matter was reported to the police. Apparently, the priest had left the island.[222]

4.186 Tony Jordan first worked at HDLG as a volunteer before being taken on. He would play snooker with the children and take them swimming. When he took them swimming this would be logged in the day book.[223]

4.187 WN7 volunteered in the summer of 1975 to work at HDLG. He was not supervised, but he remembers that staff were always around. As a volunteer he came and went as he pleased, making himself known to a member of staff when he arrived. There was no register that he had to sign. There would have been times when he would have been alone with children. He would be there to help with meals and bedtime.[224]

4.188 A qualified teacher remembers volunteering at HDLG between 1974 and 1976. He found it a good experience. He was working, at the time, in a school where children he says were caned on a regular basis. He says that, as a volunteer, he was not aware of any caning at HDLG or of anything that made him think it was not a "*caring environment".* He remembers working in the 'C' group – "*children who had police involvement".* He found WN532 and WN587 "*very caring".* Had he had any concerns he would have gone to them.[225]

4.189 There appears to have been a formal arrangement between Children's Services and Southampton University regarding student placements at the Home.[226] There was also a system of checking and follow-up in place by 1978 in relation to local student volunteers.[227]

[222] WD006425
[223] Day 94/7
[224] Day 66/40
[225] WD006729
[226] WD006653
[227] WD006660; WD006659

Staff: recruitment

4.190 The Inquiry is specifically tasked with considering the recruitment of staff. A sample of those recruited during this decade is as follows:

4.190.1 WN287 (1973–1974): qualified residential CCO with the Home Office letter of recognition (including a child psychology course). References were provided which were taken up: assigned to Claymore group but left after three months because the Home was "*just too big".* Some of the staff she met were qualified nursery nurses, others unqualified.[228]

4.190.2 Marion Robson (1973–1974; 1978–1982). Jim Thomson's[229] daughter, initially recruited as relief residential care worker. She had no qualifications, which was *"not unusual at that time".*[230]

4.190.3 Wendy Castledine (1974–1978; 1980–1984/5). Part-time night nurse; worked previously in the UK in child residential care but no previous experience as a night nurse.[231]

4.190.4 Ernest Mallett had been a volunteer at Haut de la Garenne and returned to work there in December 1981; by that time, he had acquired training and residential care work experience in the UK.[232]

4.190.5 William Gilbert (1976–1979). Certificate in the residential care of children and young people and had been in charge of a unit, within a remand home, of 13 "*disturbed adolescent boys".*[233]

4.190.6 WN570 (1971–1974; 1977–1983). Held an NNEB qualification but told the Inquiry "*none of that equipped her for Haut de la Garenne".* Jim Thomson asked her to return in 1977, by which time she was a

[228] Day 76/130
[229] Superintendent 1976–1983
[230] WS000583
[231] WS0006000
[232] WS000602; WD006481
[233] WD006555; WD006554

residential CCO; accommodation was provided for her at Haut de la Garenne.[234]

4.190.7 Morag Jordan (1970–1984). A qualified nursery nurse for young children; when she started she was allocated to work with children of all ages at HDLG.[235]

4.190.8 Tony Jordan was encouraged by Morag Jordan to apply to work at HDLG; he had no qualifications in child care and no experience. He worked at the Home for several years.

4.190.9 Gordon Wateridge was a joiner and carpenter and had been in the Army. He was interviewed by Patricia Thornton, Charles Smith and Colin Tilbrook.[236]

4.190.10 One member of staff (1970–1974) carried out part of her practical training for the NNEB qualification at HDLG, at the end of which she was given a full-time job by WN532 and 587, working in the nursery and as a carer working in what she calls "*the family unit".*[237]

4.190.11 WN872 (1975–1980). Provided "*day fostering*" for five years and was then recruited to work in Dunluce with "*all the delinquents sent to the Home from the Courts".* Non-residential.

4.190.12 WN873 (1976–1978) started work at HDLG only because that was the only way in which she and her fiancé, who was already working in the Home, could get accommodation.

4.190.13 WN704 (1977) took up a full-time job at HDLG, having qualified as a residential care worker.[238] She joined with WN640, who had no qualifications but had helped in running a FGH in the UK.[239] He was

[234] Day 110
[235] WS000621/2
[236] WS000742/2
[237] WD006730
[238] WD006775; WD006754
[239] WD006536; WD006535

taken on part time as a Houseparent, but also to do manual jobs at the Home.

4.190.14 WN831 (1977–1978) had certificates in home management, family care and parent craft. She had worked in a Home in England and then for a local authority as a social work assistant before being offered a job at HDLG, following an interview with three people. She was in her 20s. She was given a room in the Home and allocated Dunluce to work in. She was not kept on after a probationary six months. In his reference following her departure, Jim Thomson said that she was unpopular with staff and children and he described her as lacking "*the qualities of tact and compassion".*[240]

4.190.15 WN668 and WN714 (1974–1976) applied for senior roles at HDLG through an advertisement in *New Society*. Both were qualified nurses who had worked in the UK in a children's home with children with behavioural problems. They left HDLG in part because they felt "*pushed out by other staff".*[241]

4.190.16 In 1996, WN532 (Superintendent 1974–1976) gave a statement to the UK police relating to Richard Owen. He described how Richard Owen was recruited to work at HDLG. Charles Smith (Children's Officer) spoke to WN532 about employing Richard Owen as a residential care worker. He was previously an officer in the army but in 1974 was employed as a chef in Jersey. WN532 was told that he was well recommended and multi-talented. "*If I remember, the job was practically his before the interview as he had some strings pulled for him. He was taken on as was (WN871) … They were in charge of young children in a family group. In those days I am sure that no references were asked for and no checks were made on their previous character".*[242] Elsewhere, WN532 says that Richard Owen

[240] WD006661
[241] WD006724
[242] WD006749

and WN871 "*were effectively imposed upon us, though we had no objection as we had every confidence in Mr Smith's judgment".*[243]

4.190.17 WN871 had no qualifications when she was recruited alongside Richard Owen; nor, from her account of Owen's background, did he.[244]

4.190.18 Richard Owen was employed from 9 January 1975 to the 26 November 1976. It subsequently transpired that, in 1966, Richard Owen had been convicted in England of unlawful sexual intercourse and had been made the subject of a probation order for two years. The 1966 conviction was not known to Children's Services in Jersey. In 1998, the Jersey Child Protection Team were informed that Richard Owen had been "*convicted in the UK of offences against underage girls, including at least one charge of rape … hese offences took place in the UK after he left the Island. Staffordshire Crown Court have sentenced him to 4 years*".[245]

4.190.19 One member of care staff recruited in 1975 or 1976 was about 25 when she started, having had no previous experience of child care. She worked with two different age groups and was at the Home for about 10 months.

4.190.20 WN159 (1977–1979; 1980) had no previous experience or qualifications when she was taken on in 1977 to work as a Child Care Assistant in Baintree.

4.190.21 When WN751 applied for a senior role at HDLG in 1979, it is recorded that the Children's Officer asked the SOJP to carry out a check at the Criminal Records Office.[246]

4.190.22 WN102 (1978–1984) was originally engaged in an administrative role on a part-time basis but stated that in practice she worked full

[243] WD006213
[244] WD006557
[245] WD006534
[246] WD006642

time. The extra hours included "*taking charge on occasion to looking after the children, night nurse and even the laundry".*[247] Other domestic and non-care staff appear to have started work without filling out an application form.[248]

4.191 Early in Jim Thomson's tenure as Superintendent, he identified reasons for staff turnover being high:

4.191.1 younger staff with NNEB training were no longer working with the age range for which they were trained; the child population at the home had become predominantly teenage or late primary school;

4.191.2 staff were having to work several evenings until 10pm or later: "*they have to cope with problems of teenage children, never mind problem teenagers".*

4.192 He proposed recruiting older "*and more mature staff".*[249] He also identified resentment by staff that they could not qualify for residency in the island and he was concerned residential care staff were being discriminated against.[250] In December 1977, there were only 16 child care staff, as opposed to the 20 considered necessary.

4.193 Problems recruiting staff were also a constant theme throughout 1978. It was raised by Jim Thomson with the Children's Sub-Committee at a meeting in April 1978. He was having difficulties recruiting suitable staff because staff with children had problems ensuring suitable arrangements for their own children. The committee allowed one existing member of staff, WN656, to have her child with her during working hours but said that this would have to be reviewed on a case-by-case basis by the committee.[251]

[247] WD006757
[248] WD006807
[249] WD002616
[250] WD002616
[251] Day 42/76

Staff: induction, training and exchange of information

4.194 The Inquiry heard differing evidence about the extent of information sharing and the training of staff during this period. WN715 (Superintendent 1973–1974) was critical about the absence of training:

> *"… I thought the Home was about thirty years behind its time … because even accepting that Haut de la Garenne was grossly understaffed, what staff there was did not appear to be fully trained in childcare … understaffing was a big problem … a problem that stemmed from above at Committee level … they were insular … they would employ local people as opposed to someone better qualified from outside … in England we would go on conferences and courses … out in Jersey they were not up to date with the current facilities."*[252]

4.195 At the start of this period, Colin Tilbrook sends a memo to all staff in October 1971, alerting them to proposed in-service training in general child care matters during 1972, in association with North-West London polytechnic: "*the arrangements are almost finalised and it is hoped that study courses will start fairly early in the New Year."*[253] There is no other evidence before the Inquiry on whether training did in fact take place as envisaged.

4.196 WN287, (1973–1974) although at HDLG for only a short time, received no training when she started, saying "*I do not remember seeing any policies or procedures".*

4.197 WN570 said that in the absence of formal training she followed the lead of more experienced staff,[254] as did Marion Robson. Fay Buesnel worked at HDLG for 10 years, eventually being appointed Matron. She said that *"there was not a written code of conduc*t". New staff would be given a verbal *"run through*" but nothing in writing.[255]

4.198 Marion Robson received no induction when she started; she recalled one training event during her time at HDLG *"when David Pithers came from the*

[252] WD006781
[253] WD008613/81
[254] Day 110
[255] WD006916/20

National Children's Home".[256] There are also records of in-house training provided in 1979, and of a residential course in 1981, both about working with adolescents in residential care.[257] Further training appears to have been provided by the National Children's Home between 1984 and 1986 – records show that there were supposed to be 12 modules over the two-year period.[258] Marion Robson remembers staff were required to attend meetings: *"there were staff meetings talking about the children, different plans, what was going on and there was a general hall meeting when everybody got together, but there would be individual ones between the groups as well".*[259]

4.199 WN102 (1978–1982) says that she never had any formal training "*so used my skills as a mother when I worked at HDLG. I remember being called to the Home on about three occasions when children were misbehaving and they seemed to calm down when I arrived to speak to them. My philosophy was to treat the children as I would my own".*[260]

4.200 WN704 (1977–1982) remembers that she was the only one with formal qualifications and had no formal training in the four years that she was there.[261]

4.201 In the statement that they prepared for the police in 2008, WN532 and WN587 (Superintendent and Matron from 1974 to 1976) recollected:

> "*We … set up a training system to bring the staff more in line with English standards and had people from linked areas of work to talk to the staff and answer questions about their work with children. For instance the psychologist gave a talk and the chief probation officer and also the children's officer himself."*[262]

4.202 A memo from WN532 in 1976 records 30-45 minutes of "seminar type meetings" every morning in which staff could discuss problems with children

[256] WD006919/23
[257] WD005778; WD005777
[258] WD005265; WD004123; WD006990; WD002615
[259] Day 76/6
[260] WD006810/5
[261] WD006776/3
[262] WD006213/9

or particular incidents.[263] The extent to which these happened in practice is unclear.

4.203 WN570 (1971–1974; 1977–1983) could not remember any training being given in the 12 years she worked at the Home. WN287 received no training when she started and did not recall seeing any policies or procedures.[264]

4.204 WN715 (Superintendent 1973-1974) did not think that the training of staff was up to the standards he had reached in the UK. He thought the Home was about 30 years behind although he thought that there was no awareness of this at the Education or Children's Sub-Committee level: what staff there were did not appear to be fully trained in child care. He felt that local people would be employed as opposed to someone better qualified from outside.[265]

4.205 Comments made by the Education Committee's Working Party set up following the 1981 Lambert and Wilkinson Report provide a useful snapshot of the training position across the board at that time:

> *"It was noted that staff at HDLG are keen to participate in any form of training programme that might be established. It was felt that particular attention should in fact be paid to providing ongoing in service training for all our residential staff, particularly those expected to deal with difficult or disturbed children and adolescents. It was noted that the majority of our residential staff have received no formal training in residential social work with the older child yet were expected to cope with a wide range of difficult and disturbed children in the older age group."*[266]

4.206 When Mario Lundy was sent to work at HDLG in 1985, he found that the staff there were "*untrained and unqualified*".[267]

4.207 WN7 told the Inquiry that sharing of information about children was based on informal communication.[268] Staff would be briefed by the Superintendent or Child Care Officers about the reasons for placement.

[263] WD002617/2
[264] WS000594/4
[265] WD006781
[266] WD002598
[267] Day 74/191
[268] Day 66/90

He recalled that there was no formal induction into post, no formal training and no formal supervision.[269]

Staff: relationships with children and culture/atmosphere

4.208 Staff recollections of relationships with the children during this decade vary:

4.208.1 Marion Robson (1973–1974) could not remember ever sitting down to discuss the emotional needs of child but told the inquiry that bedtime was good time for one-to-one contact with children: *"I always loved to read to the children and they very much enjoyed it."*[270]

4.208.2 WN287 (1973–1974), although only at HDLG for three months, found that because there were so many children in the Home, "*you just could not build a relationship with them. They were all over – or they seemed to be at the time … running from group to group … you just could not keep it together".*[271] Making relationships with children in a Home "*amounts to a lot".* She worked for a short time with teenage girls in the Home "*you do whatever you need to do to care for the children".*

4.208.3 WN552 (early 1970s–1979) remembered: *"sometimes we were a bit stretched … So, you know, individual attention you were trying to give … A bit impossible really".*[272] She recalled that "*we were not told a lot of the background at the time".*[273]

4.208.4 WN570's (1971–1974; 1977–1983) first impression when she started work in 1971 was that the Home *"seemed a happy place".* She thought it was unrealistic given the scale of the Home to have expected staff to look after the emotional needs of children in their care, "*… now looking back obviously there were too many children*

[269] Day 65/62
[270] Marion Robson, Day 76
[271] Day 76/134
[272] WD006935
[273] WD006935/19

and not enough staff … the staffing never changed … there was never the opportunity to have as much time as these children should have had with adults … we did the best we could at the time … too many children with too many problems".[274]

4.208.5 WN570 remembers a system of children being specifically allocated to certain members of staff: *"you had a relationship with those children. It was practical things, for example birthday presents, Christmas presents, school parents evenings if their parents were not going".* The member of staff and the child would remain paired throughout the child's time at the Home. Children did form relationships with staff, "*and then they [the staff] left and it was upsetting".*[275]

4.208.6 WN671 (1972–1973) remembers that it was a relaxed and happy environment, *"the staff were young, the kids content and visitors were welcomed".*[276]

4.208.7 Another member of staff (1970–1974) who worked with children up to 11 remembers that the children were treated in a caring manner, "*we cared for them and we were like supplemental parents, looked after them the best we could".*[277]

4.208.8 WN871 (1974–1976) describes HDLG as a *"happy place".*[278]

4.208.9 The positive accounts are at odds with the impression gained by WN870 (Matron 1973–1974), who had spent 12 years working in children's homes in the UK*: "I would describe [the children's] treatment as harsh. They were not cared for. They were minded rather than cared for. The children were a nuisance to the staff, especially the nursery group. There was no loving atmosphere at all. But this [was not helped] by the fact that it was very understaffed.*

[274] WN570, Day 110/32
[275] WN570, Day 110/47
[276] WD006769
[277] WD006730/5
[278] WD006731

This made all aspects of running the home difficult".[279] *… "[the children] were controlled by staff in a negative manner. There was a total lack of personal relationship between the staff and children".*[280] She gave the example of the younger children at the Home, who had to be dressed for bed very early: "*this was usually so that the nursery nurses could get off early and go out … the children would then have to occupy themselves with minimum supervision until they went to bed … the staff showed no genuine care for the children … It was just a job".*[281]

4.208.10 When WN870 started, one of the main areas that needed changing *"was the staff need to start treating the children as individuals. The children did everything together and there was a shortage of staff".*[282] …".*I have never witnessed a children's home run quite like Haut de La Garenne where children were not their priority*".[283]

4.208.11 WN584 (1974–1980) remembers that the care staff "*were always shouting and bawling at the kids*" but that when he first started it was a "*happy place".* By the time he left in 1980, staff morale was at its lowest, "*everybody was getting bitchy".*[284] WN159 (1978–1979; 1980) says that, looking back now, the Home was very institutionalised.[285]

4.208.12 WN587 (Matron 1974–1976) spent *"quite a lot of time"* during her working day "*with individual children talking through their problems trying to understand their needs and providing support for them".*[286]

4.208.13 WN831 (1977–1978) recalls that the senior staff when she was there – Jim Thomson, Fay Buesnel and WN781 – *"did not seem to want to interact with the children. That to me was odd".* The person in charge

[279] WD006782
[280] WD006783/3
[281] WD006783/3
[282] WD006783/3
[283] WD006783
[284] WD006793/4
[285] WD006720/4
[286] WD006213/11

of Dunluce *"had no regard for children whatsoever … she definitely did not want to be around children".*[287]

4.208.14 WN722 was a night nurse for two years in the 1980s. She worked at the Home one night a week, "*If a child was to cry or anything like that they would get a cuddle and get them back to sleep".* For her doing the rounds at night was like "*checking her own children".*[288]

Staff: recollection/knowledge of policies and procedures

4.209 In the 10 years that Fay Buesnel worked at HDLG, eventually being appointed matron, "*there was not a written code of conduct".*[289]

4.210 WN552 (early 1970s–1979) did not think there were any policies in place for staff reporting concerns but said that had she been concerned, "*I would have gone to senior management".*[290] WN873 (1976–1978) was given no written policies or guides and said that she just learnt from more experienced staff what to do.[291]

4.211 WN570 told the Inquiry that she could not remember there being any written staff policies or guidance that she was provided with in the time that she worked at the Home.[292] This accords with another member of staff (1970–1974) saying that there was only the hand-over book: *"it was very simplistic".*[293] She was not given any codes of practice or written rules.

4.212 Tony Jordan was never told about the ethos of the Home; all the rules he found out by being told rather than anything he was given on paper.[294] Morag Jordan[295] was not aware of the existence of the 1975 rule book (see below), but said that it accorded with her understanding of what was and was not acceptable. She said that the only real guidance she was given was to treat

[287] WD006790/4
[288] WD006957
[289] WD006916
[290] WD006936
[291] WD006794
[292] Day110/39
[293] WD006730
[294] Day 94/ 18
[295] WS000621/9

the children as she would her own and to learn from others who had worked there.

Record keeping

4.213 As Marion Robson remembers, a file was opened on each child resident at the Home and these would be kept in a cabinet in the Superintendent's office: she was not sure whether this was one supplied by Children's Services or initiated by the Home. She thinks she looked at a child's file "*once or twice*" but that junior staff were not encouraged to do so.[296] Another member of staff (1978–1983) remembers that there was a file on the children but that the Children's office had a larger file. She remembers reading files but not the background of the children, "*I just got the impression that we did not have the full history of the child available to us in the home*".[297]

4.214 In 1970, a new system of filing was introduced by Colin Tilbrook incorporating all children of one family in one file; sections relating to the family as a whole and it had sections relating to each individual child.[298] Staff did not tend to read the files. As in the previous decade there was a handover book for the day and night staff.[299] Medical records were maintained,[300] as was an accident log book.[301] Absconders were recorded separately in a book entitled "*children who truant".* Entries run from April 1974 to December 1981.[302]

Staff: duties and routines at the Home

4.215 Marion Robson (1973–1974) described the routines at the Home as "*very rigid"* but says that they were necessary, given its size, "*Without proper routines, it would be impossible to look after sixty children*".....[303]

[296] Day 76/24
[297] WD006728
[298] WD006728
[299] Day 76/27
[300] WD006213
[301] WD006777
[302] WD005732
[303] WS000583/4

Although the routines seemed old fashioned to me I understood why they were needed and could see that they helped the children to settle into the home and maintained a sense of order".[304] She told Professor Cameron in oral evidence that she thought that "*the routines and the systems were probably there to make the staff feel a bit more secure in the day-to-day job with handling so many children and of such diverse ages and backgrounds and types".*[305]

4.216 It was the same for WN287 (1973–1974) – there was "*a routine at HDLG"* but she did not find the routine regimented. She found the children "*all appeared happy".*[306]

4.217 In a paper on staffing in February 1976, WN532 set out in detail the duties of a member of staff in a group:

> *"Staff need to cope with their nursery children plus school children from 7–9 am over lunch time and from 4 until 10.30 pm. There may well be children home sick or who fall ill at school needing collection and care. Staff need to assist children to wake, dress, wash and during meal times then take turns in escorting to various schools. Return then to sort linen for their children, to take turns in visits to school for their own particular children, help with mending, escort their children to clinics or discuss with the CCO progress of their charges. They will need to attend their own group discussions (taking turns to give up their free time for same). Again they are eager to attend seminar/coffee breaks in order to glean knowledge and to express frustrations etc., when they may have nursery children to interest at the same time. Turns must be taken in collecting children from school, supervising meals and returning children to school (one driver, one escort). They will need to take a turn in collecting petrol for the van, the only time we can do being 2.15 pm. It can be that a member of staff, after the school run, will need to go to town and wait in the queue on the Weighbridge to fill up, then to return just in time to commence the escort from school. Staff need to be prepared all day and evening to assist in admitting children when there is a vacancy in their group.*
>
> *The return from school varies and covers a long period between 3.30 pm. to 5 pm. and so once more adds pressure on staff within the group. They then help the children to clear, assist in washing up and re-laying the tables. In between various bedtimes and bath times they need to help with general activities for the children in the house*

[304] WS000583/4

[305] Day 76/116

[306] Day 76/133

> *(various staff offer a session to the other groups where they try to stimulate a new hobby or interest) i.e. one gives First Aid, another netball another football, races and gymnastics, swimming, sewing, discussion groups, carpentry, chess, drama – to name a few.*
>
> *Senior staff try to offer a Youth Club atmosphere in the activity room with snooker, darts and bar football etc. All of this type of activity will be open to the house thus relieving pressures and widening the children's horizons.*
>
> *Staff may need to escort children to various outside clubs, i.e. Cubs, Scouts, Brownies Guides, Ambulance Brigade, Boys' Brigade, Discos etc.*
>
> *We also encourage our children to bring their friends home and need to offer a homely atmosphere where a child can relax with a game, books or just to chat."*[307]

4.218 WN532 remembers that staff, including Morag Kidd (at the time) and others, "*found it difficult to change to our ways of thinking about how the home should be run".*[308]

4.219 One member of staff remembered the routine as *"the shift rota that I worked was varied, it would be 7 am to 4 pm or could be split shifts, 7 am–12noon and then 4 pm to 10 pm or 1 pm to 10 pm. Once the children of school age had left for school there were less staff needed during the day so it could be that you would work a split shift, and once the children had returned from school there would be more staff".*[309] This is how WN661 (1976–1984) remembered her working day.[310]

4.220 Fay Buesnel remembered the work being very structured and very hard: "*you were working with 15 children and with just two of you on duty and many times were over 60 in numbers".*[311]

4.221 The vast majority of children were educated outside of the Home in States of Jersey primary and secondary schools. Two categories of children were taught at Haut de la Garenne for short periods of time; (a) the new arrivals who had not been transferred from their old school and (b) those excluded

[307] WD002617
[308] WD006800
[309] WD006730
[310] WD006777
[311] WD006916

from school. A qualified teacher was employed at the Home for about 18 months between 1975 and 1976. She taught those excluded from school and the class size ranged from six to nine pupils.[312]

Contact with Children's Services

4.222 Marion Robson recalled "*no real interaction between Children's Services and Haut de la Garenne. I got the impression that Children's Services would visit occasionally but I have no recollection of regular meetings taking place to discuss the welfare of the children placed there. I think the temptation at the time was to think of children at Haut de la Garenne as being 'sorted' and to that extent it could be described as a 'dumping ground.'"*[313] She found that there was no "*open system between the fieldworkers and the residential workers, no overt communication".*[314]

4.223 WN831 (1977–1978) who had been involved in social work in the UK could not recall children at HDLG having contact with their social worker, although by the standards of the time she said that this was not surprising.[315]

4.224 WN7 (1975; from 1979) remembers the relationship between residential staff and CCOs as being cordial; at the time children were not often involved in their own reviews. CCOs would come into the unit and speak to the child and to him if it was one of his allocated children. He had never attended a meeting where a child had made a complaint to their CCO.[316]

4.225 Gordon Wateridge (1970–1974) remembers there being very little contact with the Children's Office. On occasion, he met with Charles Smith, whom he found "*very indecisive".* He has no memory of attending any case conferences.[317]

[312] WD006805
[313] WS000583/13
[314] Day 76/73
[315] WD006790
[316] Day 66/3
[317] WS000742

4.226 Morag Jordan described the lack of communication between staff and Child Care Officers as *"a disgrace".*[318]

4.227 WN570 spoke regularly with the children's allocated CCOs. The frequency of visits to the child depended on the particular CCO: there was no consistency of approach; the views of the residential staff on the child's emotional wellbeing were not sought. She was not aware of care plans for children.[319]

4.228 The apparent uncertainty about the division of responsibilities between Children's Services and HDLG, reflected in 1979 correspondence between Jim Thomson and Charles Smith,[320] was identified in the Lambert and Wilkinson Report in 1981:[321]

> "*The Children's Officer acts as the external manager to Haut de la Garenne but it is not clear how he exercises this managerial responsibility except in administrative terms and at times of major crisis. Certainly, there are no regular meetings between the Homes management team and the Children's Officer and many of the decisions taken by the Children's Sub Committee would be taken at officer level within any other social work department … As a major establishment, the Committee should consider the general policy for Haut de la Garenne, but should leave most management matters to be dealt with by the Children's Officer."*[322]

4.229 When Mario Lundy was seconded for three months from Les Chênes in 1985 to "trouble-shoot" the last remaining group at HDLG, he told he Inquiry that he had "*regular contact with the Children's Officer. Terry Strettle was effectively my supervisor so I would speak to him frequently, he would come and visit. On at least one occasion the Director of Education came up and spent the evening with the young people".*

4.230 Mario Lundy remembers discussing with Terry Strettle the circumstances of the children left at the Home.[323] He also recalls that social workers "*visited their children quite frequently*" while he was there in the mid-1980s.[324]

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[318] Day 94/30
[319] Day 110
[320] WD002606
[321] WD007382/56
[322] Day 42/78
[323] Day 74/190
[324] Day 74/192

Staff: accommodation and off-duty

4.231 One member of staff (1972–1973) recalled that staff regularly had parties and that the Home was a good place to work from a social point of view.[325] WN668 (1974–1976) said that staff were allowed to have parties, *"this was also their home … so as not to disturb children they would be moved to other bedrooms for that night only".*[326] Fay Buesnel remembers that the staff "*all socialised together … we all went drinking together. They were my friends".*[327]

4.232 One care worker (1974–1976) had happy memories of his time working in Jersey and at HDLG: "*the social life was great and there was always a lot going on".*[328]

4.233 WN7 remembered staff parties held in staff accommodation and that girlfriends, boyfriends and "*other people we knew*" would be invited.[329] He described some staff accommodation as a *"seven-bedroom staff flat so that every member of staff had their own bedroom, communal kitchen, communal lounge, communal bathroom".* There was a strict rule that children never came through into the staff flat.[330]

4.234 WN636 (1974–1976) said that *"people who went to the parties would be found wandering around the home or sitting on the stairs unsupervised. This would be both males and females".*[331]

4.235 WN587 said that Morag Kidd (Jordan) would organise parties that were *"too rowdy for a children's home. These parties had been part of the Haut de la Garenne routine way before we took over the running of it and it would have been difficult for us to put a complete stop to them so they did continue".* She recalled Jim Thomson was a regular attender.[332]

[325] WD006954
[326] WD006724
[327] WD006918
[328] WD006425
[329] Day 66/102
[330] Day 66/89
[331] WD006721
[332] WD006801/3

4.236 There was some controversy about these parties: in 1973, when a visitor was removed by the police and Jim Thomson said there should be no more parties until further notice. In 1977, a car accident after a staff party received media attention, a temporary ban was imposed by the Children's Officer and such parties were defended by Jim Thomson:

> *"Staff here will accept that because HDLG is a Children's Home, of necessity certain constraints are inevitable in the area of social life, but these constraints must be sensibly balanced against the fact that for many this is effectively their home in Jersey and they are fully grown adult men and women."*[333]

Visitors to the Home and home visits

4.237 Weekend home leave started on Friday. Children were taken by staff to their homes, although some were collected. They returned on Sunday. All visits had to be agreed.[334]

4.238 A memo in 1972 suggests that vetting of those having children to stay over was seen as discretionary:

> *"I am in complete agreement that the parents of any of the children's school friends should not normally be subjected to any prior investigation. I consider however that where a child intends to spend a night away from HDLG more detailed information about the family is required. Will you please ensure that in future the Child Care Officer concerned is advised when a boy or girl is to spend a night with anyone other than his/her own immediate family and recommend whether or not you consider any further investigation is necessary. We can then decide what if any action needs to be taken."*[335]

Discipline: general

4.239 When she started there in 1970, one Housemother remembered the Home being a disciplined environment as opposed to a loving one; she received no structured policy on discipline; there was no recording of disciplining by then. She found the use of discipline in the home on the whole "*acceptable".*[336] WN552 (early 1970s–1979) cannot remember

[333] WD008619; WD002609
[334] WD006730/9
[335] WD004357
[336] WD006016

recording any punishments. She never saw a child being restrained.[337] WN7 remembers that he followed the guidance of others when disciplining children. He would give children a tap on the back of the legs – there was no formal guidance. He felt that all staff were aware of the boundaries of acceptable punishment.[338]

4.240 Colin Tilbrook maintained his position that children were not to be hit. In a memo addressed to "all staff" in February 1971, he made plain his views:

> *"May I firmly remind all members of staff that no child, whatever the provocation, is allowed to be hit slapped pulled or pushed around under any circumstances or called names or be sworn at. No child is to be removed from a bedroom or recreation room and be forced to stand alone in draughty corridors or similar places. If for any reason a child needs to be removed from the group a member of staff must be with the child at all times and the child should be adequately clothed and comfortable. If a child is not responding to normal discipline a senior member of staff must be informed."*

He concluded in unequivocal terms:

> "*I cannot support any member of staff who disregards this general ruling."*[339]

4.241 WN532 and WN587 (Superintendent and Matron 1974–1976) maintained that "*throughout our career staff in our employ have always been instructed never to smack, hit or in any way physically discipline a child".*[340] WN587 remembers that if "*there was a need to reprimand any child he or she would be removed from the situation which would often be the end of the matter. The preferred punishment was the removal of privileges such as pocket money or hobbies*". She could not remember corporal punishment being used when she was there.[341]

[337] WD006936
[338] Day 66/16
[339] WD008612
[340] WD006213/15
[341] WD006801

4.242 In October 1979, Jim Thomson produced an "*outline of our disciplinary code*" which he sent to Charles Smith, the Children's Officer.[342] Corporal punishment (although not for girls) and detention were the most serious options. Other sanctions were to be used "*depending on the nature of the offence and the age of the offender".* He took the opportunity to set out his general approach:

> *"As superintendent, I have always taken a pragmatic line on the question of punishing children between the ages of 5 and 11 years by smacking on the bottom or the hand. Previous superintendents, notably Mr Tilbrook, completely banned staff from smacking children of this age group with the result that children would mock staff in this respect. The guidelines are what a good and sensible parent might do in similar circumstances. Smacking on the face and head is expressly forbidden."* [underlining in text]

Discipline: corporal punishment

4.243 WN715 (Superintendent 1973–1974) told the police that he was "*well known for being against corporal punishment and have always tried to earn the respect of children in my care".*[343]

4.244 Marion Robson remembers that staff were allowed to smack the younger children on the bottom or on the hand. This accords with another member of staff (1970–1974).[344]

4.245 Marion Robson thinks she would have been aware of Jim Thomson's 1979 guideline (see above).[345] She did not think that in the times she worked there that there was a *"culture of robust physical punishment".*[346]

4.246 Fay Buesnel remembers that any use of the cane was recorded in a typed memo to Children's Services; each child's social worker would be copied in. Jim Thomson would call the child's social worker beforehand[347] and the child's parents would also be notified.[348]

[342] WD002605
[343] WD006780
[344] WD006730
[345] Day 76/49
[346] Day 76/100
[347] WD006916
[348] WD006920

4.247 There were examples in evidence before the Inquiry of formal memos recording children having been caned, the number of strokes and the reason for the punishment. The memos were sent to the Children's Officer and the relevant CCOs.[349]

Discipline: use of detention rooms

4.248 WN715 and WN870 (Superintendent and Matron 1973–1974) were against the use of the detention rooms and wanted the system changed:

> *"For example there were two rooms that were used as detention cells if a child absconded. The Constable would complain to the children's committee who would in turn complain to the children's officer when that child was found. We would be instructed, ordered really by the children's officer to lock them. This would mean putting them in one of the rooms and locking them in it. We did not keep children in there very long because we disagreed with the practice. I cannot really remember what those rooms were like or what was in them because we used them so little."*[350]

4.249 In 1974, Jim Thomson, as Senior Child Care Officer (SCCO), writes to WN532, "authorising" him to place a boy in detention "*for as long as is permitted by Home Office regulations*". The boy had shown himself to be "*completely untrustworthy and unworthy of any kindness and compassion you have shown* [him]".[351]

4.250 WN668 (1974–1976) remembers the two *"secure rooms … were at the front of the house … "":*

> *"The bed was a built in concrete bed with a mattress. The room was carpeted and had central heating. There was a bell inside to ring if the child wanted to go to the toilet and if they rang the bell then staff would let them out to go. They did not have their clothes taken off them and they would have books, comics etc to look at. It must be remembered that some of the children in there were difficult to handle and would have violent tantrums, and if there was a staff shortage then children would be put in the secure room. Very few children would be in the room all day and all night and when they were in there they would be supervised."*[352]

[349] WD002782; WD002745; WD002746, WD003632, WD0005421/2-5; 8

[350] WD006782

[351] WD001486

[352] WD006724

In her time, "*girls were not usually put in the secure rooms".*

4.251 The rationale for the punitive use of the detention rooms appears to have changed from the previous decade. Under Jim Thomson's tenure, the length of time in which girls were placed in the rooms was extended to meet the behaviour of a particular "*type of girl".* He writes to Charles Smith in February 1978, when notifying him that he is punishing WN120 and another girl:

> *"For a long time I have been convinced that the maximum 48-hour stretch at one time in detention was inadequate for this type of girl. They do it 'standing on their heads'. I therefore propose that WN120 (and X when she returns) shall spend at least seven days in detention, with proper regard for regular exercise and fresh air. The regulations provide for up to fourteen days' detention in special circumstances … As for WN120 we have suffered her moods, her disruptive and deviant behaviour for well over a year. We have shown great patience. She is a prime mover in all female absconding and since the middle of 1977 there have been fifteen incidents of female absconding as against only three male incidents. The time has come to teach her a lesson … . "*[353]

4.252 It is not entirely clear what regulations Jim Thomson is referring to, since there were none in force in Jersey regulating the use of secure accommodation. The reference to 14 days suggests that he may have been applying *regulation 11 of the Community Homes Regulations 1972*.[354]

4.253 Marion Robson remembers the detention rooms being used routinely for children who absconded. She remembers that meals would be served on plastic plates so that children would not harm themselves. She had no authority to place a child in detention. She says that the rooms were not "*used lightly".*[355] She thought they were only to be used for 24 hours but not "*days on end".*[356]

4.254 WN570 remembers that children would only ever be in detention for one or two nights; she never had concerns about its use.[357]

[353] WD001292
[354] LG000081
[355] Day 76/47
[356] Day 76/59
[357] Day 110/44

4.255 WN661 (1976–1984) remembers the rooms being used to put one girl resident in when she was drunk.[358] Another member of staff (1978–1983) remembers the rooms being used for aggressive children, who would be taken there to calm down: "*they would be physically carried or escorted down".* She remembered children being put there in their night clothes so that they would not run away.[359] WN102 says that they were put in their night clothes "*so as not to harm themselves with clothing that might be used to cause injury".*[360]

4.256 One member of staff (1974–1976) remembers WN28 "*behaving very badly and needed to be reprimanded by being placed in a room alone at the front of the building, again I am not proud but the only way to get to the room was to drag him along the corridor. After being in the locker room WN28 was seen waving from the window to the other children so the whole idea of the reprimand was fruitless".*[361]

4.257 WN7 (1975; 1979–1981) remembered one incident in which he had to help carry a boy by his arms and legs to the detention rooms. The boy had been "*acting out".*[362] WN7 also recalled that every Superintendent he worked under or with was reluctant to use the detention rooms.[363]

4.258 Gordon Wateridge (1970–1974) says that the detention rooms were used for two reasons: first, when a child arrived who was known to be a "trouble maker" they would be placed in the detention room for a couple of days until they assessed by a child psychologist or psychiatrist. The other reason was if a child was "kicking off".[364]

4.259 Fay Buesnel (1974–1984) remembers there being a bell in each of the two detention rooms, which could be rung to alert the staff member that the child wished to use the toilet. The toilet and shower were outside the detention

[358] WD006777
[359] WD006728
[360] WD006810
[361] WD006425
[362] Day 65/93
[363] Day 65/127
[364] WS000742

rooms. When someone was to be put into a cell there would have to be two people (staff) or a police officer present. The child would be searched then they would shower and put on their pyjamas and a dressing gown in the detention room: a child would be kept in for a maximum of 24 hours. There were no toilet facilities in the detention rooms. A record was kept in a book to show who was kept in the detention rooms.[365]

4.260 WN102 (1978–1982), who worked in an administrative role at the Home, remembers that each use of the rooms generated a memo that would be put into the child's file kept at the Home.[366]

4.261 WN532 and WN587 (Superintendent and Matron 1974–1976) were not comfortable with the existence let alone use of detention rooms:

> *"We were under direct orders from Charles Smith that if a runaway child was returned in the middle of the night they were to be placed in a detention room overnight only. We were not very comfortable with this and had never seen detention rooms in the other homes in which we worked, but we understand his reasoning, namely that the child needed to be locked in to ensure that they did not run away again … The police were quite dictatorial, did not like dealing with runaway children and we think Mr Smith was driven to the conclusion that it would be better if they were kept secure until we could properly counsel them the following day. These children were never kept in a detention room longer than the remainder of the night that they were returned … A runaway child who was returned during the daytime did not go into detention, but just returned to their group."*[367]

4.262 Jim Thomson appears to have been aware of the limits on the use of the detention room – in August 1978, when addressing the issue of over-16s at the Home, he told Anton Skinner, then the SCCO:

> *"This age group continue to pose us rather special problems. Most of them have already failed in the community, sometimes several times. Drink is a problem with most of them … We can offer shelter board and lodging friendship if they are prepared to conform to our general routine which with some modifications for this age range is primarily designed for school age and younger children. Our only sanctions with them are*

[365] WD006920

[366] WD006810

[367] WD006213/10

> *loss of privileges and in the last resort detention. The last named sanction is not available if they are working."*[368]

4.263 In December 1978, Jim Thomson introduced mandatory 24-hour detention for school-age children involved in any offence involving drink – he described under-age drinking as one of the Home's "*principal problems*".[369]

4.264 In June 1980, Jim Thomson drafted rules for the use of secure rooms: they are detailed and exhaustive. The draft concludes: "*In general the use of secure accommodation is to be seen not so much as punitive but as an opportunity to isolate, settle and re-build bridges with a possibly hostile and unhappy young person. Its use should be brief and sparing."*[370] The draft was sent to Charles Smith in May 1980, asking him: "*Do you think that they should be endorsed at Committee level or not*?"[371]

4.265 Confusingly, a set of guidelines in the use of the detention rooms was drawn up: "*1980 use of detention or secure revised guidelines to staff".* The need for the rules followed the de-designation of HDLG as a remand centre. Unlike the longer draft rules, those for the staff include the following:

> *"Detention rooms will henceforth be used almost exclusively to enforce INTERNAL discipline."*[372]

4.266 The use of the detention rooms was deprecated by some in Children's Services. In July 1980, Dorothy Inglis wrote a strongly worded memo to Anton Skinner (then a SCCO) recording her experience of returning a resident to HDLG after she had absconded. She was placed in detention. Dorothy Inglis invoked her experience of several years as a professional child care worker, questioning "*the use of the detention room …. particularly in the cold routine fashion it is used*".[373] She then refers to WN223, one of the children for whom she is the CCO, who "*had been locked up overnight in a police cell, on her return to HDLG she was calm and co-operative yet she was locked up. Even*

[368] Day 42/85
[369] Day 42/86
[370] WD006212
[371] WD005426
[372] WD005426/2
[373] WD003413 and WD003412 (in that order)

more surprising 28 hours later she was still locked up".[374] In her evidence to the Inquiry, she observed that in children's homes in the UK that she had worked in, children were locked in secure rooms but only for the most serious offences.[375]

4.267 Two years on, the detention rooms were being used to punish WN22 for smoking. She was placed there by Keith Purvis, the Deputy Superintendent.[376]

4.268 A 1980 CCO's running diary records the CCO being notified by a member of the Home's staff that "*normal procedure for girls not working and refusing to work within the Home was a short period in detention. I said that I did not want to become involved in the internal discipline of the Home and was sure that WN223 was aware of the penalties but asked that she be given another opportunity".*[377]

4.269 An example of the notification process following the use of the detention room shows the Deputy Superintendent (William Gilbert), writing to Anton Skinner (SCCO) and David Castledine (CCO) to tell them about WN223 spending four nights in the detention room in May 1979.[378]

Discipline: other reasons

4.270 WN570 told the Inquiry that children in her group were never punished for bedwetting; she remembers that "*quite a lot of children*" were enuretic.[379] Another member of staff cannot remember ever telling off children for wetting the bed *"unfortunately this went with their history so it was just dealt with".*[380] It may be noted that Morag Jordan was convicted of one count of rubbing a girl's face in urine-soaked sheets after the girl had wet the bed.[381]

[374] WD003413 and WD003412 (in that order)
[375] WS000629/9
[376] WD002905
[377] WD002629
[378] WD003402
[379] Day 110/43
[380] WD006730
[381] WD002620/1

4.271 Marion Robson did not remember children being punished for not eating their food,[382] nor could another member of staff (1973–1974).[383] Fay Buesnel (1974–1984) stated that meals would never be saved to be re-served to a child the next day.[384]

4.272 WN871 (1974–1976) remembers that children were made to eat meals they had previously left, as well as being sent to bed for the entire day or being made to stand in a corner.[385] One member of staff (1976–1978) remembers that children would be made to sit at the table until they finished their food "*sometimes for hours*".[386]

4.273 As in the previous decade, weekend visits were cancelled as punishments as well as going out at weekends,[387] although for WN570 it was "extremely" rare to discipline a child by gating them at the weekends. Being sent to bed early, doing chores, and being made to scrub the courtyard were also used. Being fined and being grounded were the most common forms of punishment.[388] By the time that Mario Lundy went to the Home in 1985, "*ground[ing] was about it*" as a sanction. He did not think corporal punishment was available and he had no access to the detention rooms.[389]

<u>The Superintendents</u>

Superintendent WN715 (1973–1974)

4.274 The 1970s saw three changes of leadership at HDLG after the resignation of Colin Tilbrook in 1973. He was replaced by WN715 and WN870, both of whom had 12 years' experience working in children's homes in the UK – latterly as Superintendent and Matron.

4.275 WN715 and WN870 took up their appointments "*on the understanding that within three months"* WN715 would provide a report detailing what changes

[382] Day 76/23
[383] WD006730
[384] WD006920
[385] WD006731
[386] WD006795
[387] WD002905, WD001574
[388] Day 66/18
[389] Day 74/184

were required at HDLG. WN870 stated that she and her husband "*got the impression that Charles Smith wanted change*".[390] A report was submitted recommending education on the premises, the placement of children in family groups and the provision of more and better trained staff.[391]

4.276 WN715 and WN870 were against the use of detention rooms and wanted the system changed: *"We did not keep children in there very long because we disagreed with the practice."*[392]

4.277 WN715 said "*the Home was very insular and the staff were against my wife and I as we wanted change".* In spite of the report and its recommendations, the only concession to change was an extra staff member. This was not sufficient and WN715 and WN870 resigned. WN715 and WN870 met the Children's Sub-Committee to explain their reasons. WN870 "*had not expected the number of short stay children to be as high as it was and she considered that these children upset the long stay children who because they were disturbed desperately needed stability, added to this the difficulty of coping with children on remand without adequate and trained staff was intolerable*".[393]

4.278 Elsewhere WN870 reflected on the difficulties she and WN715 had faced: "*it was also obvious that Jersey did not like outsiders especially those attempting to introduce change … the other staff felt threatened by the fact that WN715 and myself were well qualified making it difficult to gain their confidence … if a few trained staff with a professional attitude had been employed that Haut de la Garenne would have changed for the better.*[394] …".*I was shocked at the way Haut de la Garenne was being run compared to what I had experienced on the mainland."*[395]

[390] Patricia Thornton had resigned as Children's Officer in 1971 to take an appointment in the UK. Her post was not filled for 18 months, during which time her deputy, Charles Smith, was acting Children's Officer

[391] WD006782

[392] WD006782

[393] WD005780

[394] WD006783

[395] WD006783

4.279 WN715 stated that he and his wife had not expected the lack of support from "*above*". He also commented (expressing a view still echoed 30 years later) "… *the finance of childcare in Jersey was not high on the list of priorities".*[396]

4.280 WN287 (1973–1974) remembered WN870: "*she was very professional and wanted changes from the set-up of how it was … we did chat about segregating the older ones*". She felt that it was WN870 who ran the Home.[397]

4.281 WN570 remembers that WN715 changed the shift patterns, which made him unpopular with staff.[398]

Superintendent WN532 (1974–1976)

4.282 In March 1974, WN532 and WN587 were appointed from outside the island. They had run children's homes in England between 1951 and 1971. WN587 was CQSW qualified and had latterly provided social work training as a part-time lecturer in residential care.[399] In the last Home they had run before coming to HDLG they had had a visiting psychiatrist and psychologist with whom they would meet regularly and who would see children at the Home.[400]

4.283 Their first impressions of HDLG were that it was run "*very much on the basis almost of a workhouse environment and run with a degree of military precision which seemed to exclude the appropriate element of best care and best practice for the children. We did not approve of what we saw and we said we were not prepared to work at Haut de la Garenne*".[401]

4.284 They were asked what it would take for them to stay and manage the Home:

> *"We were concerned that the children were not dealt with as individuals but were dealt with in large groups eating at long tables and were seen to be throwing food. We wanted to bring about a much more family atmosphere. We were concerned that the large dormitories looked very institutional and we wanted to break these down into smaller units with "parental" figures looking after children in units a bit like the system that*

[396] WD006781
[397] Day 76/131–132
[398] Day 110/8
[399] WD006676 – police timeline of careers
[400] WD006213
[401] WD006676

> *had been established in Europe and copied by us in England. We had seen this system operate when we did an exchange visit with the social services in Holland organised by UNESCO many years earlier and we very much favoured the idea of a couple being responsible for up to 15 children. So effectively the children would feel that they had permanent carers and one point of contact rather than just feeling as if they were in an institutionalised and regulated boarding school. We could divide the children by age and sex … we could keep brothers and sisters together and make sure that in age terms we did not have groups of say 6 children who were five and 8 children who were fifteen or sixteen but we could operate it on a family age appropriate situation. The idea was also to enable some of the children to develop some responsibilities for care of the younger children … we were concerned that when we first observed Haut de la Garenne some of the children were becoming institutionalised. There seemed little interaction between the children and the staff and we wanted to improve staffing levels."*[402]

4.285 WN532 and WN587 (unlike WN715 and WN870) did receive funding from the Education Committee and *"the implementation of these changes continued throughout our time"* at HDLG. They recruited additional staff from 1974. They tackled head on the scale of HDLG by dividing it into four self-contained houses with smaller numbers of all ages – living separately and eating separately: "*Our philosophy was that the staff treated [the children] as their own children … "*[403]

4.286 WN532 remembers that they turned down the post on "*three occasions … The staff would not properly control the children. The regimes and the placement of children was how it would have been in the UK about 20-25 years previous*"[404] before starting in March 1974.[405]

4.287 WN570 (a member of staff 1971–1974; 1977–1983) recalled that WN532 and WN587 wanted to change the image of the Home to show that children were there through no fault of their own:[406] "*They were more a couple working together … quite often they would come into the group … they were very hands on, they would come in and help … both of them were very good …*

[402] WD006213/5
[403] WD006213/8
[404] WD006800
[405] WD006676
[406] WD006213/8

they were very approachable to the children and the children would go and speak to them".[407]

4.288 In their approach to children, WN570 thought they were similar to Colin Tilbrook. Under WN532's tenure she said that "*this was the only attempt in all my time at the home when there was direction given from a Superintendent to improve image and to be more ambitious in our aims*".[408] Another member of staff described them as very nice and very caring, "*they were a mature couple*".[409] Fay Buesnel (1974–1984) could not remember WN532 ever caning anybody. WN668 (1974–1976) remembers them being very kind to the children but at a distance; WN587 was "*very influenced by the theoretical output by the Tavistock Clinic Theory for Disturbed Children. The Tavistock Clinic was a training organisation for child care workers".*[410]

4.289 WN871 described WN532 and WN587 as "*brilliant role models*". She remembers WN532 as being especially good with those children in constant trouble *"[WN532] would talk to them while walking around the grounds and used to sometimes allow them to visit their flat to watch television. Whenever this happened [WN587] would always be present*".[411]

4.290 A contrary view was expressed by WN636 (1974–1976) who found WN587 "*so hard*" on the children; she gave the example of WN587 getting a child to clean the floor tiles with a toothbrush. She said that she and WN694 left in 1976 because WN532 and WN587 "*would never be happy with what you had done".*[412]

4.291 WN532 and WN587 recalled that they had a doctor to come and see the children regularly (the implication being that this had not been in place previously). They set up a referral system to the psychologist "*who would*

[407] Day 110/112
[408] WS00066
[409] WD006730
[410] WD006724
[411] WD006731
[412] WD006721

sometimes see the children at his office … or he would come to the home to see them".[413]

4.292 One example of their approach is found in a memo in 1975 from WN532 to Charles Smith: it relates to a boy held in detention who needed constant supervision: "*Prior to the weekend in question I have had this boy under close supervision, fetching him out of the detention and then keeping him with either my wife or me when on duty. The boy has eaten in my flat and sat in the evenings watching TV. He has had a period of being within a group prior to getting into trouble with damaging cars and property. We found however that the boy just cannot cope with [his] peer group and needs more personal attention".*[414]

4.293 In July 1975, WN532 provided each group at the Home with a set of guidelines for staff working at the Home. Prescriptive guidance was given on all aspects of life at the Home, including punishment, tidiness, visitors, children's washing, pocket money, dining room routine, new admissions and children's leisure activities.[415] It is not known whether the Guidelines were distributed to staff and if so to whom. Many witnesses, including Fay Buesnel, say that they never received any written policies or guidance when they worked in the Home.[416] From the date on the document, it is assumed that it was compiled by WN532 and WN587 (although the text is written in places in the first person).

4.294 The guidance stated that no invitations were to be accepted on behalf of children without first consulting the Superintendent, "*No child should be allowed out with <u>anybody</u> or any organisation … unless the Superintendent has first been consulted and his agreement obtained*". Addresses of children were never to be given "*under any circumstances*"…. "*Our legal responsibilities for these children are very clearly defined and a considerable amount of 'vetting' is normally undertaken before any child is allowed to visit*

[413] WD006213/9
[414] WD006739
[415] WD002600
[416] WD006922

relatives, friends or acquaintances, even for short periods. This applies to the girls' boyfriends as well".

4.295 It addressed the need for record-keeping: *"As we are now trying to keep very comprehensive records of all matters affecting children in care, it would be appreciated if members of staff jot down on a piece of paper and hand it into the office any last minute alterations in weekend visits or visitors if these alterations appear to differ from the weekend list. Anything important which the children say about their weekends which needs investigation or help should be similarly reported. Anything to do with the children is important and will be dealt with".*

4.296 The Guidance also dealt with punishments: "*no child is allowed to be slapped or pulled about by any member of staff and no child should be sent to bed for a punishment or deprived of any part of its meal …. praise is far more important than punishment".* It stipulated that children who wet their beds "*should never be punished or reprimanded".*

4.297 Other guidance included:

4.297.1 Supervision – Staff were encouraged "*unobtrusively*" to "*wander amongst the children during the day*".

4.297.2 Children were to have a "*minimum of at least two baths or showers a week*".

4.297.3 "*Adolescents should be told that often when they are upset at their age when coming to HDLG for the first time it sometimes happens that they might wet the bed through no fault of theirs and that they and all children who do have an accident can take a member of staff on one side and explain what has happened".*

4.297.4 Staff were encouraged to stay with younger children who could not get to sleep "*until they are quiet or relaxed".*

4.297.5 The guide devotes two-thirds of a page to dining room routine, including that: "*If at the end of a meal a child has not finished*

> *because of finickiness the table should be cleared completely without comment."*

4.298 The rules on the use of the detention rooms followed almost identically those prescribed under Colin Tilbrook. In the time that WN7 was at HDLG, not all the rules set out in the Guideline were applied, although he thinks that the rules on the use of the detention rooms were.[417]

4.299 In a memo to Charles Smith in September 1975, WN532 requested approval to set up a new group so as to avoid using the detention rooms:[418]

> *" … Could we reconsider the staffing of Haut de la Garenne? Would it be possible to set up a new group? … Could we then employ large numbers and cope with one group of these disturbed children? Perhaps the closer contact and a more individual approach would be the necessary breakthrough we need."*

4.300 He said that he was "*increasingly distressed*" about the children with a history of problem behaviour. He recognised that this group needed firm control "*until they can cope with a more natural environment*" but control at Haut de la Garenne meant the use of the detention rooms, "*the most undesirable part of such procedure is that placing a child in such close confinement often results in the deterioration of relationships with adults and particularly those in authority*". The Inquiry was unable to find a response to this memo.

4.301 In February 1976, WN532 proposed an overhaul of staffing at HDLG.[419] In essence, he felt that the Home needed more staff. The paper referred to the four groups at HDLG by name:

> *"Aviemore: fourteen children – one baby (three months) and the young boy of five going to morning special school.*
>
> *Baintree: sixteen children – one baby (seven weeks), two preschools at home all day, plus others at school.*
>
> *Claymore: twelve children – one baby (ten months), two preschool, others at school.*

[417] Day 65/123
[418] WD002603
[419] WD002617

> *Dunluce: fifteen children – two preschool and two excluded from normal day need careful supervision, eleven at school all day."*

4.302 WN532 recognised the need for experienced and trained staff, *"The delinquent and emotionally disturbed children have caused concern during the past twelve months and we had an influx of new staff with limited experience. It has caused vast areas of extra pressure to senior staff who have tried to cope with these children and yet train new staff, many of whom have no idea of the fundamentals of good child care, into this demanding type of work".*

4.303 In making the case for additional staff, WN532 concluded with an anecdote:

> *"We consider there is a need for three staff to cover the period between 4–10 pm and on a 'lucky' day we can give this provision. Even so a child's individual needs may not be covered in a particular incident i.e I saw a child on a staff's lap trying to listen to a story. I returned an hour later and they were still trying! I was told that there had been so many interruptions they had been unable to get this simple task over. It was necessary to help with supervising whilst the child's story was read. If each group had five members of staff, they would be able to arrange holiday cover and hopefully have improved staffing during the school holidays."*[420]

4.304 WN532 maintained the pressure on the Children's Officer, proposing that Dunluce be made a group for "*maladjusted children*" with a maximum of ten children, saying "*we would have to give a lot of thought and planning to the care of this group … Could we get advice and help from the psychiatric clinic*?"[421]

4.305 In October 1976 WN532 was asked by Charles Smith, then Children's Officer, to identify why HDLG had advantages over a small family home. WN532 summarised the advantages of a larger home as "*economic use of labour and movement of children without breaking emotional distress. Plus the fact that senior staff should be able to guide staff into becoming more aware of a child's needs and be in a position to make the necessary provisions … a large home with small groups should show a vast improvement in daily behaviour problems*". He recognised the disadvantage of a broad range of behaviours in a larger home "*In a larger home one is constantly under pressure to have*

[420] WD002617/5

[421] Day 42/59

disturbed children inserted into a settled group. The effects can be devastating as children hear forceful bad language, meeting with bullying or are forced into sexual realisation before they are mentally able to accept [the same]". He concludes, "*with well trained staff who are dedicated to their fostered family the small unit should be [the] perfect answer to children needing care*".[422] The reference to the "small unit" is to the newly established self-contained "family" units with HDLG.

4.306 WN532 and WN587 were at HDLG for only two years and tendered their resignations in September 1976. In 2009, WN532 said in his police statement: *"We recommended to the States of Jersey that the home Haut de la Garenne be closed down and made into smaller units".* He recalled that the States responded by saying that they would then only be in charge of a smaller group type home, and *"we would be on half our wages".* This, coupled with the housing qualification on the island, meant that they could not afford to stay.[423]

Superintendent Jim Thomson (1976–1983)

4.307 Jim Thomson was appointed Superintendent at HDLG in 1976. His wife had died the year before. Until his appointment, the Education Committee's policy had been to appoint a married couple to run the Home. As a consequence of his appointment, the post of Deputy Matron was discontinued and a residential CCO was appointed instead. Jim Thomson had come to Jersey in 1966 to take up the post of CCO, then Senior Child Care Officer from 1971. Patricia Thornton noted that he was "*lacking in basic training*" but wanted to have "*a professional training*". It appears from the records available that he attended no further training.

4.308 He was appointed Superintendent in September 1976, starting in December that year.[424] He was then 48. He was Superintendent for seven years. In September 1983, he retired from the role to return to being a Senior Child

[422] WD006648
[423] WD006800/4
[424] WD006751

Care Officer (replacing Brenda Chappell who had gone on long-term sick leave).[425] He retired in 1989 and died the same year.

4.309 Former staff members gave their assessment of Jim Thomson's character and their impressions of him during his time at HDLG:

4.309.1 Wendy Castledine – "*a very caring man".*[426]

4.309.2 Fay Buesnel – "*the softest man"* who "*absolutely hated*" having to cane children".[427]

4.309.3 Ernest Mallett – *"nice guy, quite strict and clearly traumatised by the death of his wife … He was probably one of the best they had at the office … Really good".*[428]

4.309.4 WN704 – remembered a heavy drinker who encouraged a culture of drinking at HDLG: "*members of staff used to drink until the early hours, then come on duty that morning with children".*[429] She recalls that alcohol "*played a huge part in the life of Haut de la Garenne, most of the staff drank … when Jim Thomson welcomed [WN640] and I when we first arrived he offered us a whisky or a beer".*[430]

4.309.5 WN831 – remembered Jim Thomson "*spending most of his time in his flat drunk".*[431]

4.309.6 WN7 – Jim Thomson drank heavily but he never had doubts about his sobriety when working nor about his ability to run the Home. He was a kind man.[432]

4.309.7 WN715 – described Jim Thomson as "*an inexperienced and untrained social worker"* when it came to care issues.[433]

[425] WD006527
[426] Day 78
[427] WD006916
[428] Day 81
[429] WD006776
[430] WD006776
[431] WD006790
[432] Day 65/134

4.309.8 WN570 – never had cause for concern regarding Jim Thomson. She thought he was better with teenagers than with younger children.[434]

4.310 *Peer-on-peer abuse* – In 1978, Jim Thomson had to address and manage the behaviour of Michael Aubin, who had been in HDLG since the 1960s. Now in his mid-teens he had started indecently assaulting younger boys in the Home. In July 1978, by which time six younger boys had alleged they had been assaulted, Jim Thomson wrote to Charles Smith, formally requesting that Michael Aubin be removed from the Home "t*o protect our younger boys*":

> *"I feel that this matter MAY have to be brought to the attention of the Children's Sub-Committee … the situation is intolerable and the Department is laying itself open to very serious criticism if something is not done."*[435]

4.311 *Challenging behaviour of teenage girls* – During Jim Thomson's tenure, the length of time for which girls were placed in the detention rooms was extended to meet the behaviour of a particular "*type of girl*". In February 1978, he wrote to Charles Smith notifying him that he was punishing WN120 and another girl:

> "… *the maximum 48-hour stretch at one time in detention … (is) inadequate for this type of girl … they do it standing on their heads … (I) propose … at least seven days in detention … As for WN120 we have suffered her moods, her disruptive and deviant behaviour for well over a year … she is a prime mover in all-female absconding … the time has come to teach her a lesson*". He described the other girl as "*abysmally lazy, sexually aberrant towards young boys*".[436]

4.312 In 1979, a memo was sent by Jim Thomson to the SCCO Anton Skinner relating to four girls at the Home – their respective CCOs are copied in. He sets out his understanding of each girl's motivation for absconding, noting that he had consulted other staff. He concludes: "*In the case of all four a lenient policy was followed after their last adventures on the premise that being too strict was not working. The new approach worked well but briefly and may have been regarded by them as a 'loss of nerve' on the part of senior staff.*

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[433] WD006781

[434] Day 110/17

[435] WD001438

[436] WD001292

Henceforth we revert to the guidance of the Consultant Psychiatrist to the Home Office, Dr Berry who specialises in dealing with difficult adolescent girls:

> *"1. Be strong 2. Show them you care 3. Do not give in to them 4. Remain their friend."*[437]

4.313 *Running of the Home* – Within a short space of time in his new role, in January 1977, Jim Thomson identified to the Children's Officer those whom he described as the natural and most experienced of leaders in each group with whom CCOs should make contact; all are female, one of whom is Morag Kidd.[438] He notes: "*Child care staff should rely principally on them for information in the group setting."*[439]

4.314 In May 1978, Jim Thomson wrote a memo[440] to Charles Smith, entitled: "*The over-15s – 'LOG JAM'*", in which he complains that the Home has 13 children over 15; eight of whom "*have either been in trouble with the law … have serious behaviour problems, or have been here before and had to return*". He comments that, "*Their presence in such large numbers distorts our main role of a children's home and puts extra strain on our disciplinary and evening framework*". He invites the Children's Office to a joint meeting to "*embark on some positive* '*child-care action' to break the log-jam*".

4.315 As noted above, in January 1980, Jim Thomson sent a report to John Rodhouse, the Director of Education, "*Haut de la Garenne: A report for the Eighties*".[441] In the introduction, Jim Thomson wrote: "*this is a personal report based on eleven years' experience as CCO and SCCO in Jersey and on three years' experience as Superintendent of HDLG. However, I know that many of my views are shared by both Field and Residential Care Staff* …".

4.316 The report provides an understanding of Jim Thomson's approach to running the Home. Three pages into the report, he writes:

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[437] WD002090
[438] WD002618
[439] WD002618
[440] WD002607
[441] WD006984

> *"I think I can fairly claim that in the past three years at HDLG, it has not been my policy to disguise any of our difficulties or to claim that we were doing well when we were not."*

4.317 In concluding the report, he put forward several recommendations, declaring that *"Hau de la Garenne will remain Jersey's major residential child care establishment for the foreseeable future".* He considered that:

> *"Teenage girls are likely to remain the cause of most of our problems. These problems are not readily solvable by legal action and/or placement. In many areas of the United Kingdom, staff working with teenage problem girls are paid on Grade 6, so acute are the difficulties. At Haut de la Garenne, a growing number of staff are acquiring the experience, maturity and steadfastness in dealing with them. What is needed from Committee members and others in authority is a recognition of the difficulties involved, support and coolness is the face of adversity. Children in long-term care who have no parental contact, or poor and erratic parental contact, should be moved on to either Family Group Homes or Foster Parents, if at all possible."*

4.318 The paper prompted a meeting between John Rodhouse, the Director of Education, Charles Smith and Jim Thomson. Jim Thomson was asked to explain why he had taken on the role of Superintendent – he said that he wanted to maintain continuity and to strengthen the relationship between field work and residential staff. The notes record him as identifying the two main problems as teenage girls and difficult parents:

> "*He believed that Haut de la Garenne can never create the close bonding that might be available elsewhere as most children are just passing through and as a result make no firm relationships.*"[442]

4.319 The meeting appears to have ended on a curt note:

> "*During discussion Mr Thomson complained of lack of support from senior officers citing the recent happenings with* [WN136] *and* [WN139]. *The Director of Education advised him that in no way could he expect support when gross errors of judgment were made. It was suggested to Mr Thomson that in order that he was aware of group organisation he should consider taking meals within the group on a regular basis."*[443]

[442] WD005371

[443] WD005371

4.320 In his evidence to the Inquiry, John Rodhouse who was then the Director of Education, described the relationship between Charles Smith and Jim Thomson:

> *"It was a working relationship. There were times when they disagreed. Remember that Thomson had been SCCO under Charles Smith and going into HDLG he took on a different role with a certain measure of independence and I think they both had to adjust to that, sometimes successfully, sometimes not."*[444]

4.321 In their 1981 Report, Lambert and Wilkinson referred to Jim Thomson's report when reaching their conclusion that:

> "*Haut de la Garenne remains unsuitable for the range of tasks it undertakes and is inappropriate as a resource available to a present-day Children's Department … It fails to meet fully the needs of many children, particularly those with special social and emotional needs".*[445]

Keith Purvis (1983–1984)

4.322 In 1983, two groups remained at HDLG: Dunluce, run by Keith Purvis, and Aviemore, run by Fay Buesnel (Campbell). He had joined HDLG with considerable experience in England, having been a Superintendent of a Home for 18 children. By 1983, however, management at HDLG was under strain and a group of staff confronted Keith Purvis about his lack of leadership.[446] Later in the same year, at a meeting with Charles Smith, he was told that the Sub-Committee was not satisfied that he could "*carry out the duties and responsibilities of being responsible for a small children's home*".[447]

4.323 In September 1984, he was forced to resign and was replaced by Mario Lundy. Terry Strettle was then in post as Children's Officer.

Mario Lundy (1985)

4.324 Mario Lundy (then Deputy Principal at Les Chênes) was seconded by Terry Strettle, then Children's Officer, to HDLG to oversee the last group of children

[444] Day 92/51
[445] WD007382/59
[446] WD006641
[447] WD006640

before the closure of the Home. In fact, he stayed at the Home for only three months, until February 1985. There were 16 children in residence. In evidence to the Inquiry,[448] Mario Lundy said that:

4.324.1 staff were demoralised and that the building was "*on its last legs*";

4.324.2 the behaviour of some of the children was "*off the wall*";

4.324.3 there were no formal processes for children raising concerns and no staff raised any issues about children. He had concerns about bullying among some senior boys;

4.324.4 there was no effective leadership, nor effective sanctions for poor behaviour. There was no culture of training and development;

4.324.5 he had regular contact with Terry Strettle at Children's Services, who also visited the Home;

4.324.6 he tried to introduce a token system for calculating pocket money; this was not linked with home leave. It was not effective and was undermined by one staff member;

4.324.7 he was seen as a "*military man*" introducing structure, rules and regulations.

WN751 (1985–1986)

4.325 In September 1985, WN751 took up the role as Officer in Charge of a greatly depleted HDLG; eight boys were in residence. WN751 remained in post until December 1986.

4.326 He introduced staff supervision[449] and appears to have been responsible for the implementation of training, mostly provided by the National Children's Home and David Pithers.

4.327 He wrote a summary report in March 1986[450] and commented that he was appalled "*to see so many members of staff, with so many skills,*

[448] Day 74/171–194

[449] Day 42/90

afraid to use the skills in case they are reprimanded. This I believe is a throwback to earlier days of Haut de la Garenne".

4.328 A further passage in his summary report states:

> "*I should point out that I believe still in tender loving care and in both groups, it is the foundation of all our work. Work which depends on relationships and not purely on discipline".*

4.329 The importance attached to the need to build relationships was not new; it had been a constant theme in reports and memos of other Superintendents over the previous 25 years.

Inspections of Haut de la Garenne

4.330 In this period, there were a number of reports, which provide an insight into the management and organisation of HDLG. They were:

4.330.1 The Home Office Inspection (1964);

4.330.2 The Home Office Inspection (1970);[451]

4.330.3 The Keith Barette Report (1975);

4.330.4 The Pilling Report (1980);

4.330.5 The Lambert and Wilkinson Report (1981).

The Home Office Inspection (1964)

4.331 The Home Office Children's Department Inspectorate carried out an inspection of the "Jersey Children's Department" in November 1964, including its "residential provision". The Inspector spent two days at HDLG. The Report[452] identified the changes about to take place in the Home:

> "*It will be used as a reception and assessment centre receiving among others children remanded by the Court, as a short stay home for children who families are passing through temporary difficulty and as a long-stay home for children whose emotional or behavioural difficulties*

[450] WD002615

[451] WD006194

[452] WD006689/8–15

> *make it unsuitable to place them in foster homes or family group homes."*

4.332 The Inspector noted that the Committee had "*wisely sought to attract and keep staff of good calibre by the provision of excellent living conditions and by its policy of seconding freely to training courses*". He went on to comment:

> "*Under less imaginative or more authoritarian direction, it would be difficult to avoid so successfully the pitfalls into which the basically institutional design of the premises could well lead. Everything possible has been done however, by the division of large dormitories, by excellent furniture and furnishings, to overcome its inherent drawbacks."*

4.333 The Inspector found the "*present regime*" to be "*enlightened*", "*It is forward looking in that it aims consciously and consistently at rehabilitation. It seeks to restore the fabric of each child's individual and social life, not merely to inculcate unreasoning obedience".*

The Home Office Inspection (1970)

4.334 In April/May 1970, two Home Office Inspectors (Ms Cuffe and Ms Heady) carried out a review of the work of the Jersey Children's Department.[453] They inspected HDLG and their findings, in summary, were:

4.334.1 *"Since the appointment of Mr Tilbrook … a great deal has been done to modernise methods of care in this large establishment. The highly institutional building has been transformed in many ways."*

4.334.2 *"The Committee has also agreed to a generous staffing ratio so that staff hours of work are reasonable and … compare favourably with the standards on the mainland."*

4.334.3 The number of children cared for should not be expanded beyond 60.

4.334.4 At the time of the visit, 24 of the 57 children in residence were under school age. The nursery wing, having been designed for 10 small babies, was not satisfactory for this larger group of children.

[453] At the date of the inspection, 60 children (up to school leaving age) could be accommodated. A nursery extension had been built.

4.335 The Report recommended:

4.335.1 changes in the age grouping and reorganisation of staff duties;

4.335.2 restriction of the numbers at HDLG to 60;

4.335.3 the creation of a separate small establishment for difficult older boys near maximum employment opportunities;

4.335.4 consideration of the particular needs of difficult older girls.

4.336 The Inspectors viewed the detention rooms that had been recently added and concluded:

> *" … the two detention rooms provided in the new wing of Haut de la Garenne will continue to be used for the short-term holding of young people. We consider that special care is needed when these rooms are in use for the purpose of restraining a young person. Although constructed in such a way that physical hazards have been reduced to a minimum, the rooms are situated away from the main centres of activity. It is therefore of paramount importance that when anyone is locked into the room, one member of staff should be personally responsible for the supervision".*
>
> *"Our visits and discussions at Haut de la Garenne left us with the overriding impression that this major element of childcare provision has been allowed to develop much too independently. It was constantly described to us (both by the Superintendent and the Children's Officer) in terms which somehow gave it a life and identity … apart from the functioning of the Children's Department as a whole".*

4.337 Finally, the Inspectors were particularly concerned that staff training should be improved in all areas. They met with the Education Committee in September 1970 to discuss their findings.

4.338 When one of the Inspectors revisited the Home in 1972, she noted that the groups of children had been formed, that this worked well, and that staff morale appeared to be high.[454]

[454] Day 42/20

The Keith Barette Report (1975)[455]

4.339 Keith Barette gave evidence to the Inquiry about his role as a member of the Children's Sub-Committee in the 1970s.[456] He was appointed to liaise with HDLG; he reported back to the Education Committee who minuted his views:

> *"Mr Barette considered that Haut de la Garenne was much too large and many children must feel overwhelmed by the size of the institution. He was concerned about the child who entered Haut de la Garenne because of a family breakdown then came into contact with children with bad behaviour problems and the effect this contact would have on him.*
>
> *Turnover of staff … Stable relationships should be formed between the children and staff … it was unfortunate that children who had come into the home following their rejection by their parents should again appear to be rejected by staff who left Haut de la Garenne in search of other work.*
>
> *Those children who behave badly tended to receive more attention …. It was therefore necessary for a child who craved or required attention to behave badly in order to receive attention".*[457]

4.340 In evidence to the Inquiry Keith Barette said: "*I got the impression that it was thought by the staff absolutely essential to keep everything running smoothly and that the children did not kind of get the upper hand in disciplinary matters and that everything worked fairly efficiently. But perhaps not enough emphasis on caring for the children themselves. It was a big problem. How do you control seventy children unless discipline is seen as set out and observed?"*[458]

The Pilling Report (1980)

4.341 John Pilling from Kent County Council visited HDLG in May 1980, and his report was widely referred to in the course of this Inquiry. His concluded view was that routine at the Home was essential to maintaining control but this had

[455] WD002630
[456] Day 98
[457] WD002630
[458] Day 98/62

become paramount at the expense of meeting the needs of the resident children:[459]

> " … *My observations of the way children, on arrival home from school, were programmed to change their clothes in a non-personal kind of way, coupled with the expectations placed upon children at meal times, would lead me to believe that the smooth running of the institution has become the primary focus within Haut de la Garenne. The repression of spontaneity that so often characterises childcare establishments was in evidence. … The outcome of this is in my opinion an establishment that is preoccupied with maintaining its equilibrium and forgetting to look in detail about meeting the needs of disadvantaged children – the raison d'être for the establishment's existence in the first place."*

4.342 John Pilling bemoaned the fact that the Home appeared no longer to have an idea of its function.

4.343 In evidence to the Inquiry, John Rodhouse, Director of Education, accepted that John Pilling's criticisms of the governance of HDLG was fair.[460] In our view, John Pilling's conclusions, about a major institution under the control of the States of Jersey, are damning.

The Lambert and Wilkinson Report (1981)[461]

4.344 As previously referred to on numerous occasions, in 1981 the UK's Department of Health and Social Security carried out an inspection of Children's Services. The Education Committee specifically requested that they examine the role of HDLG and comment on the way it was organised, it being "*the main residential childcare establishment*" in Jersey.

4.345 At page 49, the Report starts with a brief history of the Home – noting that the premises were upgraded in 1973 and "*a more overt policy of family grouping was introduced … the all-age groups have been more successful, living in 4 relatively autonomous house units".*

4.346 The Report noted that, by 1980, with falling numbers, one of the units had been closed. The dilemma presented by the Home was identified:

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[459] WD002595

[460] WS000619/14

[461] WD007382

> *"In general terms the Home seems to have two primary functions Firstly, as the major and most accessible residential resource on the island it provides a ready facility for a great deal of emergency and short-term care. Secondly, it is currently acting as a long stay children's home for a substantial group of young people who have spent many years at Haut de la Garenne. It is not difficult to see that these two tasks could easily be in conflict and it is our view that this is the current situation and highly unsatisfactory"*[462] The authors had gone on to look at the numbers of children going through the home in the previous 2 years: *"The figures show that over half the children have been resident between one to five years, with nearly a fifth of the children experiencing long-term care up to eleven or twelve years. Again, one should stress that it is the comparative size of these groups which is the cause for concern."*

4.347 The Report saw the placing of groups of siblings together as a virtue of the Home:

> "*One of the important features to note at HDLG is its capacity to accommodate larger families, and this is certainly one of the most noticeable things about the stream of short stay admissions. More importantly quite large families (up to seven children) can be accommodated and this is obviously a bonus in any service. One of the other patterns that emerges from the analysis is that many families of children come in and out of care on a fairly regular, if short-term basis. Their developing familiarity with the setting at HDLG could be counted a bonus, especially as attempts are always made to group the family together. On the other hand, the location of the home and its size, must be a continuing cause for concern especially where very small children are involved.*"

4.348 Other concerns raised included:

> *"The communal places and particularly the playing fields immediately surrounding the home remain rather barren and lacking in stimulation … The building has the feeling of an institution … t is not suitable for many of the tasks in which it is currently engaged [paragraph 24.11];*
>
> *… the living groups still tend to be rather too large for the staff to work creatively there is too much reliance on routine and a rather more structured lifestyle than is necessary [paragraph 24.1;*
>
> *The long stay children had less than a fair deal. They appear as a group who have emotional needs that are not being fully met … Our view is that this situation must deepen the frustration of the child whose emotional needs seem never to be adequately met. Many of the long stay children at HDLG exhibit disturbed behaviour as they pass through*

[462] WD007382/49

adolescence; and this could put them at risk when they leave to live in the community. [paragraph 24.19];

We were particularly concerned about the pre-school children … there is a pressing need to see that their physical social and emotional needs are being met [paragraph 24.21]".

4.349 The Report considered discipline and referred to the use of "*separation rooms":*

"On the whole the common behaviour problems are those of disobedience, non-co-operation and temper tantrums. These and other minor matters of indiscipline are dealt with by care staff at the group level. They tend to use a traditional tariff of sanctions which includes early bed times, fines, extra duties and in serious circumstances the loss of a day or whole weekend leave at home. If the latter is agreed then the CCO is informed and involved in the decision. The Superintendent is also allowed to use corporal punishment on boys between the ages of ten and fifteen. He uses this sanction sparingly.[463] *The other means of control at the disposal of the Superintendent is the use of the two single separation rooms …. originally intended as the children's remand facility …. but currently they are used for more difficult older girls*. *The Superintendent has drawn up clear guidelines for the staff on the use of the rooms and generally it would be expected that this will be minimal and infrequent. The rooms are reasonably safe, but not built to current DHSS specification of secure accommodation.".*

4.350 The Report stated that "*staffing Haut de la Garenne has always been a problem and there is a fairly continual turnover at the lower grades*". There was an urgent need for a programme of staff development and training. The location of the home, five miles out of St Helier, was considered no longer feasible for children in their early teens as it was considered isolated.[464]

4.351 The authors made a number of recommendations,[465] the most important of which was that HDLG should *"be replaced by more suitable alternative forms of provision*".

4.352 A working party was set up to review and implement the recommendations. The working party included John Rodhouse (Director of Education), Charles Smith (Children's Officer) and Anton Skinner (Senior Child Care Officer). At

[463] WN715, WN532 and WN587 were all against corporal punishment and it appears did not use it. When Jim Thomson was appointed in 1977, it was reintroduced. Jim Thomson took what he described as "a pragmatic line"

[464] Day 42/29

[465] WD007382/79

one meeting, it was noted that the Education Committee had insisted that all admissions to residential care should be to HDLG "*unless exceptional circumstances prevailed*".

4.353 The doors of HDLG closed as a residential children's home in 1986, at which time there were eight adolescent children in residence.

Governance

The Children's Officer

4.354 Patricia Thornton resigned as Children's Officer in 1971 to take up a post in Portsmouth. Her post was not filled for another 18 months, during which time her deputy, Charles Smith, was acting Children's Officer**.** In their joint statement provided to the police WN532 and WN587 described the Children's Officer as their "*direct line manager*".[466]

4.355 It was the Children's Officer, rather than the Superintendent, who took formal disciplinary action against staff at HDLG. He did so on behalf of the employer, the Education Committee.[467]

The Education Committee and the Director of Education

4.356 The Director of Education was the senior civil servant answerable to the Education Committee.

4.357 John Rodhouse was appointed as Director of Education in 1973. As noted above, there is a record of his meeting with Jim Thomson to discuss the latter's "Haut de la Garenne: A report for the Eighties". There is also a letter from John Rodhouse asking Jim Thomson to come and see him to discuss why the latter remained off duty following a series of fire raising incidents at the Home which had been brought to his attention by Charles Smith. The tone of the letter suggests that Jim Thomson was being asked to provide an explanation.[468]

[466] WD006213

[467] See, e.g., WD006656 relating to WN689

[468] WD006753

4.358 In 1983, staff from Haut de la Garenne wrote to the Education Committee expressing their concerns about proposals for a new Home to replace HDLG at St Luke's Vicarage and noting that they felt it ironic that children would be placed there through "*no fault of their own"* while delinquent children would be placed at the "*ideally located"* Les Chênes. The Committee noted the comments but did not accept the staff's views.[469]

4.359 In his evidence to the Inquiry, John Rodhouse,[470] said that he was "*from the very beginning aware that Haut de la Garenne was a problem … I would not have wanted a child of mine to have to go there. There was not a lot of warmth".* When asked how he discerned that John Rodhouse replied:

> "*the way the staff talked to and about the children. And also … my wife had children from Haut de la Garenne in her classes at Mont a l'Abbe school and she learned a great deal about life in Haut de la Garenne from them … children with learning difficulties, but they were quite able to talk to her about how they lived … there was not the sort of warmth that I would have liked there to be in their relationship with the children … [The staff] did not talk about the children in the way that I would talk about my children".*[471]

4.360 Although the qualifications of staff were "*not great*", John Rodhouse said "*I do not recall meeting anybody from or at Haut de la Garenne who I felt should not be working with children".*

4.361 John Rodhouse recalled that in 1974, having failed to persuade WN715 and WN870 to stay in post both he and Charles Smith thought that HDLG should be closed down.

4.362 John Rodhouse explained why this did not happen at that time:

> *"… I think we have to go back to the system in order to deal with that. In order to close Haut de La Garenne the Education Committee would need to have the support … It could only be closed on a proposition presented by the Education Committee to the States … in order to get that proposition to the States and approved by the States that proposition would have to be discussed with, in considerable detail, the Finance and Economics Committee, the Establishment Committee and … if it meant occupying other properties in the island, the Housing*

[469] WD006210

[470] Appointed Director of Education 1973

[471] Day 92

> *Committee … those committees all acted independently of one another so that what Charles Smith and I were asking the President to do was to start on a very uphill task. And we're talking about shutting down something which was part of Jersey's history. … it was a major undertaking when it did happen and it was a very very great undertaking to consider back in 1975".*[472]

Culture of Haut de la Garenne: residents' perspective (1960–1986)

4.363 The evidence from former residents of HDLG covers the entire period of its existence from 1960 to 1986. The evidence is presented as a whole since understandably many recollections are imprecise as to exact dates. The following is a summary of views about the culture at HDLG.

4.364 WN340,[473] admitted in 1959, gave an insight into life at the Home in the early years of its operation. The daily routine began with a 7am awakening, followed by breakfast. If she was late for breakfast she had to see Matron and forgo breakfast. On return from school children would do chores or watch television; sometimes they were locked in the lounge to watch television for up to half an hour. They were punished with shoe cleaning duty if they did not pay attention to the evening news. This account was corroborated by WN485[474] and WN233.[475]

4.365 WN158,[476] resident from 1954 to 1960, described dormitory routine as "*Army style*"; beds were upturned if they were not made up to the requisite standard.[477]

4.366 WN484, resident during the 1960s, described clothes being taken away on admission and children being made to wear clothes from the Home's wardrobe. This was, she said, an example of the "*regimented lifestyle*" and she saw HDLG as a punishment for the children sent there.[478]

[472] Day 92/44
[473] WS000143/4
[474] WS000247
[475] WS000139/5
[476] WS000193/4
[477] WS000193/4
[478] WS000246/4

4.367 WN99, resident from 1969, stated the children were like "*feral cats*"; the staff never showed affection and it was always "*kids versus staff".*[479]

4.368 WN217, resident from 1977 to 1980, described the stigma of being a child from HDLG: *"it was the place where all the abandoned children were put. It was the kind of place that everyone was dumped*".[480] This sentiment was reflected in the evidence of many former residents. WN217 also said that staff would just sit in their office smoking all day. Similar evidence was given by WN382, resident from 1976 to 1983.

4.369 WN167, resident from the late 1970s, described constant belittling of the children by the staff; *"it was a daily drip feed of being told that you were useless*". It was a culture of divide and rule and this made her feel insecure.[481]

4.370 A key theme among the evidence given during Phase 1a of the Inquiry was the problem of the mixture of children at HDLG. Children with significant behavioural problems and difficult domestic circumstances were placed with those staying for short periods due to illness or domestic crisis. WN343 said that the former had a significantly more difficult time and were very unhappy.[482]

4.371 The issue of the public perception of HDLG resonates throughout the evidence. Despite the fact that many of the children had needs, often unmet by the care system, a common perception in Jersey was that all of the children in the Home were "*bad*" or "*naughty"* for one reason or another. Even if their behaviour was not the ground for their admission, any child from the Home was tarnished with a bad reputation. Many children from other homes spoke of being threatened with being sent to HDLG.[483]

4.372 An insight into how some parents of children at HDLG viewed the Home is contained in a letter written by the mother of WN3 in February 1977. It was

[479] WS000349
[480] WS000387/26
[481] WS000641/14
[482] WS000146
[483] WS000430/4

written to Charles Smith,[484] Children's Officer, and echoes a number of themes in the evidence:

> "*I will agree that the place is comfortable and that the meals are adequate but I am disgusted to find that my … innocent children are put with juvenile delinquents. They have been there six days and there have already been many serious incidents … I do not think it is fair to put … well-behaved children with others that have done wrong … I could take anything as punishment for myself but when I see you putting … innocent children through hell, I'm afraid it makes my blood boil … I want you to tell me how much longer you intend to keep my children from me."*

4.373 WN382 described mixing those admitted as a result of neglect with young offenders as a form of abuse in itself.[485]

4.374 WN341 described a sexualised atmosphere in HDLG in the 1960s with the boys and the staff alleged to have sexually assaulted the girls on a regular basis.[486]

4.375 Witnesses resident in the 1970s also described a sexualised environment. It is alleged that Gordon Wateridge, who was convicted of sexual abuse of girls at the Home, encouraged boys at HDLG to carry out sexual assaults on the girls. WN397 said *"This type of conduct was usual.*[487] *There was no one to tell".*

4.376 WN167 alleged that Superintendent Jim Thomson told her that she would be put on the contraceptive pill at the age of 15. She remonstrated with him, saying that she was a virgin. She said that he wanted no one pregnant on his watch and that "*they were all at it".*[488] There is evidence that the girls were subject to an intimate physical examination by a doctor if it was suspected that they might have been sexually active.[489]

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[484] WD003209; Day 59

[485] WS000643

[486] WS000242/4

[487] Inviting the boys to grope her breasts: WS000251

[488] WS000641/8

[489] WS000188/4

4.377 This was the case even in 1980, according to WN392. Richard Davenport (CCO) was present when she was intimately examined by a doctor after staying out all night on several occasions.[490]

4.378 A particular feature of HDLG – notably in the 1970s – was a problem with children absconding. By March 1977, this was described as an "*absconding epidemic*".[491] The punishment was isolation in the detention rooms or corporal punishment. The Inquiry has heard a wealth of evidence about children being picked up by the police – Honorary Police or SOJP– and returned to the Home, with little or no attention being paid as to why they were absconding.

4.379 Many former residents spoke of incarceration in the detention rooms as the most damaging aspect of their time at HDLG.

4.380 WN217 told the police in 2013 that when she absconded, punishment was detention: – "*the worst part … throughout my life until I had therapy … being locked up all the time. The taunting while you're in there … most frightening experience … no need to lock children up like that. We weren't monsters".*[492]

4.381 A memo recorded an incident in April 1979 when a member of the public remonstrated with staff about the use of detention cells for the punishment of WN217 who had absconded. Jim Thomson, Superintendent, judged this "*to be a completely naive, if sincere, amateur do-gooder. She expressed horror that a girl could be placed in a 'cell' when what she needed was 'help.' I politely advised her not to get involved and reminded her that I had 50/60 other children in my care".*[493]

Findings: Haut de la Garenne (1970–1986)

4.382 Overall, in our view, the organisation (including recruitment and supervision of staff), management, governance and culture of HDLG in the period under review was far from adequate when measured by the standards of the day.

[490] Day 51/75
[491] WD001432
[492] WS000387/28
[493] WD003221/29

4.383 The scale of HDLG meant that the Home could never have been expected to provide other than institutionalised residential child care. Such institutions were deprecated in the 1946 Curtis Report in the UK.

4.384 The complaint by Dorothy Inglis about the use of the detention rooms was justified. Secure rooms were not used in the UK at that time, save for the most serious of circumstances and only as a means of last resort. In the UK, the use of such rooms was subject to strict regulation and required the approval of a senior member of the local authority. There was daily review and regular assessment of the child by a medical practitioner. They were never used to control or contain children.

4.385 The recommendations set out in the 1981 Lambert and Wilkinson Report could and should have been addressed earlier. The Jersey Care Leavers' Association submitted, and the Panel agrees, that the issues identified in the report are "of a recurring nature":

4.385.1 funding (competing with the education and health sectors);

4.385.2 lack of policy or policies;

4.385.3 lack of political interest;

4.385.4 difficulties recruiting and retaining qualified staff (exacerbated by Jersey's unique housing situation and policies).

4.386 It is clear on the evidence available that by 1975 at the latest, Haut de la Garenne was not "fit for purpose". John Rodhouse, Director of Education and Charles Smith, Children's Officer, both recognised that at the time but nothing changed.

4.387 Vetting – From the anecdotal evidence provided to the Inquiry it appears that there was some ad hoc vetting of visitors, but that there was no formal system in place except as set out in WN532's 1975 Guidelines. In our view this probably accords with the prevailing standards of the time. We note that while all visits by children to their homes had to be agreed, the vetting of parents of any of the children's school friends was discretionary.

4.388 Staff recruitment – There appears to have been no minimum qualification standards for care staff taken on at the Home in this period. The mix of ability and experience among recruited staff was wide ranging and seemingly unrelated to their role as carers at the Home. We find that while this may have been the approach to recruitment in children's homes at the time, it meant that staff were ill equipped to deal with the behavioural and emotional challenges posed by children placed in the Home. We note the lack of experienced staff in WN715's view *"stemmed from above at Committee level"*, in which the approach was to recruit someone from within the island and not from outside who may have been better qualified. This has been a recurring theme over the whole period.

4.389 Staff: training/supervision/induction – During the 1970s, there was little, if any, training, and that which did exist appears to have been done on an ad hoc basis. There was no formal supervision of staff at the Home during this period. In 1981, the lack of training was noted by Lambert and Wilkinson. WN570 who worked in the Home for 12 years over this period never had any training while she was there. There were other examples. We find the lack of training to have been lamentable and inadequate according to the standards of the time.

4.390 Staff: engagement with children – There are mixed accounts. Some staff remember the Home being "happy". Others say that there was no engagement with children, that staff were overstretched, and that organising the children in the home was just part of a job. As WN870 commented: "*I have never witnessed a children's home run quite like Haut de La Garenne where children were not their priority*". We take note of the fact that this observation is echoed in the comments at the time of Keith Barrette and John Pilling, and repeated by John Rodhouse in his evidence to us. We find that staff at the Home failed to engage properly with children. It may be that this failure was a consequence of numbers and scale leading to regimentation (John Pilling's view). Those responsible for the Home – the Education Committee, the Children's Officer and Children's Sub-Committee, and the Director of Education lacked the professional vision and political motivation to change.

4.391 The evidence we heard leads us to conclude that children placed at HDLG were not prioritised by Children's Services and that they were, in effect, as described by Marion Robson, "sorted". This, we find, allowed for little or no planning for the child's future.

4.392 Discipline: Detention rooms – We note WN532's stated reluctance to use the detention rooms – he told the police in 2008 that he had never seen detention rooms in other homes in which he had worked. He was right to see the use of the rooms as resulting in the deterioration of relationships between the child and adults in authority. Rather than place an absconding child in one of the detention rooms, WN532 thought they should be returned to their group. We contrast this with the approach adopted by Jim Thomson. We find that he promoted the use of the rooms for disciplinary purposes (see his 1980 Guidelines and the reference to the rooms being used "almost exclusively to enforce internal discipline"). We cannot see any justification in using the rooms in this way. This was an inadequate and inappropriate way to manage discipline in the Home and should not have been allowed to continue.

4.393 In her evidence to the Inquiry Dorothy Ingles, then a CCO with children placed at HDLG recounted an episode in 1980 demonstrating what she considered then as now the misuse of the detention rooms used to place a child who has run away. She told the Inquiry that when children absconded she tried to find out why they had done so. Her approach is to be commended. We heard of no systematic attempt to discover why children were unhappy enough to abscond. In our view, even by the standards of the time this exercise of power over a child was arbitrary, unprofessional and wholly unjustifiable yet despite the concerns expressed by the CCO was allowed to happen.

4.394 Superintendent WN715 – Given the scarcity of evidence in relation to WN715's short tenure as Superintendent at the Home, we cannot come to a finding on the adequacy of his management of the Home. We note that he was "shocked" at the way the Home was being run when he took up his appointment and how far behind the times he felt it was. We see this as in part a criticism of Colin Tilbrook's legacy. We note also WN715's proposals for changing the Home and his analysis of why his proposals were not carried

forward – he felt that there was lack of support from the Education Committee. He also commented that "*The finance of childcare in Jersey was not high on the list of priorities".* This is a view that we have heard expressed in evidence to the Inquiry by others and in different eras.

4.395 Superintendent WN532 – We note WN532's description of the Home when he took up his appointment in 1974 as being run on the basis of "*a workhouse environment and run with a degree of military precision which seemed to exclude the appropriate element of care and best practice for the children".* Again, this demonstrates to us that by the time Colin Tilbrook had resigned in 1973 the Home had been allowed simply to function as an institution. The management of this children's home in the 1970s fell significantly below the accepted standards.

4.396 We find that WN532 did try and introduce change in the Home. We note that he recommended that the Home be closed down and made into smaller units. During his period of management, the Home was in a period of transition. He and WN587 were committed to the Home and managed it adequately in the short time they were there.

4.397 Jim Thomson – At the time that Jim Thomson took on the role of Superintendent, he already considered the Home to be unmanageable and unsuitable for children. This, in our view, informed his approach to the management of the Home which appears to have been reactive rather than constructive. By 1980, he noted that the Home was not doing well and had several difficulties. Despite the challenges, in general, the views of former staff members about Jim Thomson's management of the Home were positive, in spite of evidence of his heavy drinking. We find that Jim Thomson's management of the Home was inadequate, although this was largely due to the intrinsic problems within HDLG at that time.

4.398 In our view, Jim Thomson's approach to the behaviour of teenage girls at the Home in 1978 demonstrated a lack of empathy, an absence of concern for the needs of the girls in question and a concentration on punishment and control rather than any attempt to understand the reasons for the girls' behaviour.

4.399 Keith Purvis, Mario Lundy, WN751 – we do not have sufficient evidence to make our own findings about the management of the Home by any of these individuals, due to the short periods in which they were in charge. By this time, the Home was being de-scaled following the recommendations of Lambert and Wilkinson.

4.400 Inspections – we note that there were relatively regular external inspections of HDLG during its existence, whether by the Home Office or others. However, during the 1970s, there were no inspections.

Heathfield

Recruitment

4.401 The former head of the Dunluce Group at HDLG, WN751, oversaw the transfer of children to Heathfield and remained until the summer of 1987, when Geoff Spencer took over as Principal Officer.[494] He had previously worked in the UK and had a certificate for social work.[495] A condition of the appointment was that he lived in this accommodation annexed to the Home.

4.402 Geoff Spencer told the Inquiry that in Jersey, staff were not expected to have qualifications. Everyone in the UK that he encountered had a basic child care qualification. People from Jersey were appointed as opposed to those from the mainland. This was partly driven by uncertainty as to how long non-Jersey staff would stay[496] and also due to the fact that child care staff from outside Jersey would, unlike teachers, not be provided with accommodation by the States.[497] There were also volunteer workers for whom there was no vetting system in place.

4.403 Sean McCloskey began work at Heathfield as a volunteer in 1987. He was subsequently appointed in 1989 to the post of Residential Child Care Officer; no qualifications were required and no background checks were carried out.[498] returned to work at Heathfield for a year in 2008, having worked for the SOJP.

[494] WD004671
[495] WS000590/2
[496] WS000590/9
[497] Day 75/25
[498] WS000576

He recalled that the Manager at the time was a man named Kevin, likely to be Kevin Parr-Burman.[499] By this time, contrary to his earlier stint at the Home, he recalls there being a lot of policies and he went through them with his Manager.[500]

4.404 An Act of the Education Committee from March 1988 suggests that police checks as well as references were a part of the application process. The document shows that an applicant had been offered a role at Heathfield subject to the receipt of satisfactory references. However, a police check had shown a conviction seven years previously, for domestic assault. The offer of a position was withdrawn, despite an appeal and a politician pointing out the applicant's involvement with youth work and good standing in the community. It is noted:

> *"… it was not appropriate in this instance that he should be looking after vulnerable children in a residential home, as this would put the reputation of the Children's Service at risk … it had not been felt that it would be fair to the other staff at the Home if a criminal record could be ignored, especially when there was violence in that record. It might be possible to find a position within the Education Service, but it would not be one caring for disturbed youngsters*".

4.405 Phil Dennett moved to Jersey in 1989, having qualified as a social worker in the UK and obtained a Master's degree in Management and Leadership in Health and Social Care. He was appointed to the Senior Residential Team at Heathfield. He had qualified as a social worker in the UK, obtained a master's degree in Management and Leadership in Health and Social Care and worked in a residential children's home and as a social worker for a number of years. He described staff turnover as "*low*" and said they built up an experienced "*base of staff"* during this period.[501]

4.406 Tony Le Sueur began work as a Senior Residential Child Care Officer at Heathfield in 1991, having spent a decade as a youth worker. He recalled having a brief interview, but thinks that Geoff Spencer made enquiries about his suitability through colleagues in the Education Department. He said that

[499] WS000576/29

[500] Day 69/157

[501] Day 95/17

the only available qualification in residential work at that time was from the UK Home Office; it could not be obtained from Jersey.[502]

4.407 Kevin Parr-Burman commenced work as Centre Manager in April 2004. He had worked in the UK in a secure unit for 18 years and had managed a children's home for two years. In 2008, he was noted to be "*very experienced in working with young people who present with challenging behaviour and has been trained in child protection issues and is skilled in crisis intervention*".[503] Following an allegation of assault against a resident, Kevin Parr-Burman was moved to La Preference.

Training

4.408 Geoff Spencer said that most of the staff had no formal training during his time in charge, and that there was concern about staff skill levels; no suitable NVQ courses, no training of temporary staff and a high staff turnover. He arranged for some staff training in the UK and for Barbara Kahan[504] to come to Heathfield to do some training.[505] He said that he gave supervision sessions and would carry out his own informal inspections.

4.409 Sean McCloskey said that there was very little training for residential CCOs, but he did receive some training from Pat Curtis (from the UK), completed an Open University course of his own accord and also received some training provided by Dorothy Inglis.[506] He said that there was little policy guidance available when he began and did not recall seeing the "Home Statement" produced for Heathfield.

4.410 Susan Doyle started working at Heathfield in February 1991 having previously worked at Blanche Pierre for two years. She described it as a "*wonderful place to work"* and said that she received supervision and training while she was there.[507]

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[502] WS000619

[503] WD006059

[504] Barbara Kahan, author of Psychological Well-Being of Children

[505] WS000590/10

[506] WD006098/5

[507] WS000604

4.411 Tony Le Sueur said that training was difficult to organise for residential carers as trainers were flown in from the UK, usually for a week. If they wanted to attend training they would do so during the day, then go straight onto a shift. These sessions were therefore difficult to fit in. He thought that Department savings were, and still are, often made by cutting training budgets. Funding was extremely limited and difficult to access. He recalled some training from Ray Wyre and Pat Curtis, but had no "*restraint training*,"[508] nor training on de-escalating techniques and he felt that this left staff vulnerable.

4.412 In November 2000, an incident occurred in which a resident seriously physically assaulted a member of staff.[509] The Team Manager, Sarah Brace, noted "*this incident raises issues about the use of appropriate and effective restraint in order to protect children and staff. There is a programme underway with a view to train all residential staff in preventing conflict and the safe use of restraint where necessary*". Ms Brace said some staff practices "*appeared to create an atmosphere of "them and us" between the staff and children".* It was subsequently noted that the staff member in question had been on an intensive Therapeutic Crisis Intervention (TCI) training course before the incident in question.

Organisation and management

4.413 In the initial period of the Home, when Geoff Spencer was in charge, care staff worked shifts and were required to do "sleep-in" on a rota basis. Geoff Spencer was available if problems arose. Although he joined as the Principal Officer Geoff Spencer's role later changed to being a Senior Child Care Officer. He then supervised staff while running the Adolescent Services Team (AST), described above.

4.414 Geoff Spencer developed the "key worker" system shortly after his arrival at Heathfield (1987). Staff were assigned a particular child[510] to provide one-to-one support and be their liaison point. This system appears to predate a

[508] WS000619/16

[509] WD007022

[510] Three children at most at any one time

similar system introduced by Margaret Holley at Brig-y-Don in the 1990s.[511] Geoff Spencer considered the key worker system essential as it allowed staff to develop trusting relationships with residents and to identify their aspirations and whether any therapeutic intervention was needed.[512] In May 1988, Geoff Spencer prepared a document on "Introduction to play as a therapeutic method with children".[513]

4.415 Tony Le Sueur said that most of the children were of secondary school age and that difficulties could be caused when younger children were admitted, as the latter required more resources and key workers had less time with other vulnerable children. He described the inability of residential units to say no to inappropriate placements as an unfortunate aspect of operating on a small island.[514]

4.416 Geoff Spencer also told the Inquiry that he had no discretion to refuse to accept a child, although he hoped that he would be listened to if he had any concern that a child "*was not going to fit in*".[515]He noted the lack of therapeutic counselling support available compared with his experience in the UK. He raised this issue with Anton Skinner but recognised that there were budgetary difficulties.[516]

4.417 Geoff Spencer recalled that there was no formal policy guidance for staff on safeguarding issues with the residents. Behavioural problems with a child were discussed with the child. Corporal punishment was not administered.[517] We note that the first Child Protection Guidelines in Jersey were adopted in 1991, around the time of Geoff Spencer's departure from Heathfield.

4.418 The Inquiry has been provided with various documents which outline:

4.418.1 the team structure within the AST,[518]

[511] Day 69/120–148
[512] Day 75/41
[513] WD007026
[514] WS000619/19
[515] Day 75/76
[516] Day 75/74
[517] WS0005901/13
[518] WD004674

4.418.2 staff to resident ratios,[519] and

4.418.3 daily routine in logs/diary.[520]

4.419 As set out in Chapter 3, a large part of Heathfield's work in the late 1980s and 1990s involved preventative community-based work. Heathfield was split into two distinct components; the residential component run by WN669 and the preventative and community-based component run by Phil Dennett. By 1998, this had developed into a huge operation catering for 60–70 young people; it was not run by qualified social workers.[521] Young people at risk of reception into care were collected from school and taken out on activities or taken to Heathfield. The development of respite and shared care arrangements allowed some to have occasional or regular overnight stays at Heathfield. Tony Le Sueur commented that this sometimes caused disruption for the full-time residents. He thought this unfair and it was one of the reasons why he left Heathfield after four years; preventative child care could have been run from a youth centre, he told the Inquiry.[522]

4.420 Residents stayed at Heathfield for about three years according to Geoff Spencer.[523] Although he had contact with the children's individual CCO, he would not have sight of their files, nor have any detailed background reports.[524] The decision as to when they left was taken on a case by case basis; the Child Care Officer and staff determined the best course for that child. Children and, if appropriate, their parents were invited to a Case Conference. Geoff Spencer was responsible for setting up a hostel which provided semi-independent living and prepared adolescents for life after care.[525]

4.421 Sean McCloskey thought that, after Geoff Spencer left, there was more support for children leaving care. A semi-independent living area was

[519] WS000576/6; WS000619/15
[520] WS000576/14
[521] Day 95/16 and 32
[522] Day 90/28
[523] Day 75/17
[524] Day 75/10
[525] WS000590/6

provided whereby residents could live under reduced supervision and be taught life skills.[526]

4.422 Geoff Spencer left in 1991 and the Home was then run jointly by Phil Dennett and another member of staff. During this period, staff were provided with supervision in individual sessions and weekly meetings. Phil Dennett felt that the structure then in place played a part in the low turnover of staff.[527] He left Heathfield in 1998 and became "Resource Manager for Residential Services".

4.423 A "Home Statement" from the mid-1990s[528] notes that corporal punishment and locking children in rooms were banned as means of punishment, and restraint was only allowed in exceptional circumstances and had to be reported to the Children's Officer.

4.424 An example of the standards at the time can be seen from a decision by Phil Dennett to dismiss a member of staff in October 1993 in part because of her "*overly aggressive attitude with some of the children which has shown itself in being overly confrontational and using inappropriate language"* and having made "*major errors of judgment which have created unnecessary situations with children".*[529]

4.425 During Kevin Parr-Burman's time as Centre Manager of Heathfield, Phil Dennett noted[530] that the role involved full responsibility for the day-to-day running of the Home, the policies and procedures and working with young people (although that was not the main part of his job). He was responsible for writing and developing the policies and procedures, as well as ensuring that they were fully followed by staff. In terms of restraint, he noted that they followed the TCI procedure, based on early intervention and trying to manage difficult behaviour by challenging them, with physical force only used as a last resort if the young person is a danger to themselves. When interviewed by the SOJP in 2008, he could only recall two occasions on which he had to physically intervene during his four years at Heathfield. He also said that as

[526] WS000576/10
[527] Day 95/68
[528] WD004658
[529] WD004661
[530] WD006062/4

part of his role as Manager, it was part of his remit to be aware of the needs of each individual child.[531]

4.426 In 2005, a meeting was held between Joe Kennedy (Residential Manager) and Kevin Parr-Burman about his management of Heathfield as there were "*a litany of concerns*" which made Joe Kennedy worried about the culture at the Home.[532] It was noted that extra staffing and support had been provided from staff at Greenfields and new procedures and systems had been introduced. The feedback from Greenfields' staff had been that they were the only ones doing the challenging and implementing routines at Heathfield during this time. Kevin Parr-Burman acknowledged that "*Heathfield is failing*," that it had been struggling for a long time and that he had struggled to manage it. Specific problems included lack of his attendance in the unit, staff being unable to contact him out of hours, the need for a visible staff presence, and a feeling that he was minimising the problems at Heathfield. In response to the question what was wrong with Heathfield, Kevin Parr-Burman responded "*inconsistency of staff, young people not engaging, systems do not cope with behaviour, the routines are wrong".* Joe Kennedy asserted that it was essential to the culture of the Home that there was control as well as care – the symptoms of this included absconding, school conduct and behaviour management in the Home. In response to the concerns raised, Kevin Parr Burman produced a "Behavioural Management Plan"[533] to "*take closer control of the use of free time and for there to be clear consequences for young people who fail to keep to the rules of the unit*".

4.427 Phil Dennett told the Inquiry that one of the problems was that Heathfield was a 12 bedded children's home, which he said was behind the systems in the UK.[534] He felt that Joe Kennedy did not use the best choice of words about the need for "control", but that it was important that young people knew the appropriate boundaries.

[531] WD006062/6
[532] WD009026
[533] WD009252
[534] Day 134/62

Culture

4.428 Sean McCloskey described there being a positive lifestyle at Heathfield for the residents, who got on with each other and would be helped rather than punished by staff. This good relationship between staff and residents during his time at the Home (up to 1999) meant that there was no need for corporal punishment. Restraint would be used only if necessary and the staff did not have TCI training at that time.[535]

4.429 Tony Le Sueur's overall view of Heathfield was that it was well run and achieved a lot for the young people there. Its good reputation meant that CCOs would use it as the "*placement of choice"* for troubled or challenging young people who needed residential care.[536]

4.430 WN80 transferred to Heathfield following the closure of Haut de la Garenne. He described the environment as being "*too close*" and complained that they could not get away from the behaviour of other children.[537] WN616 provided a negative account of staff at the Home, saying he "*got no support from the people who were caring for him".*[538]

4.431 William Dubois, by contrast, recalls life at Heathfield in a more positive light[539] "… *very different to the other homes I had been in; it was a functioning children's home. Punishments were only given out when they were justified … Punished by being confined to your rooms, rather than any kind of violent punishment that I was used to from the other homes*". His behaviour improved and he absconded less frequently.

4.432 WN23 was admitted from Clos des Sables in 1989, following the arrest of Les Hughes, and she said that Heathfield was "*a very different environment*" from Clos des Sables; they were allocated key workers who "*made the effort*". She

[535] WS000576/13
[536] WS000619/23
[537] WS000453/3
[538] WS000435/6
[539] WS000510/7

described her anxiety when male staff were working at the Home and there was no way of locking the bedroom door.[540]

4.433 Darren Picot was a resident in 1991 and described the majority of staff in positive terms, stating that he had the "*utmost respect for the staff at Heathfield … and on the whole the staff looked after me*".[541]

4.434 In 2009, an email chain shows that when a query was raised about whether a resident could stay overnight with her friend, the Team Manager of the Child Care Team stated that it was a matter for the Heathfield staff to determine and there was no need for formal police checks in the absence of suspicions or concerns. It was stated that: "*What it needs is for you to do what any parent would do before agreeing or not",* also taking into account the age of the young person.[542]

Governance

4.435 Some examples of the governance of Heathfield by Children's Services have already been set out above, for example the involvement of Joe Kennedy as Residential Manager in 2005. Others are dealt with in Chapter 9, when considering the response of the relevant departments to allegations of abuse, for example the allegations against WN335 in 1991.

4.436 We also note that Geoff Spencer confirmed that there were no formal unannounced inspections of Heathfield during his time there (as noted in 2002 by Dr Kathie Bull[543]), which he contrasted with his experience in the UK.[544] Sean McCloskey, who was at Heathfield until 1999, gave similar evidence and thought that they only saw social workers sporadically.[545] In evidence to the Inquiry, Sean McCloskey noted that they kept logs of when CCOs visited and

[540] WS000097/7
[541] WS000097
[542] WD009367
[543] WD006417/367
[544] WS000590/5
[545] WS000576/14

would have a chat with the CCO before they saw the child, as well as sending monthly reports to them.[546]

Findings: Heathfield

4.437 The organisation and management of Heathfield was satisfactory during most of the 1980s and 1990s, when it was run by Geoff Spencer and subsequently by Phil Dennett and another member of staff.

4.438 Some staff were appointed without basic child care qualifications and people from Jersey were preferred to those from the mainland. Volunteer workers were appointed with no vetting system. We note that recruitment practices in 1988 involved police checks and that the Education Committee felt it was inappropriate to hire a member of staff with a previous conviction for domestic assault, on the basis that he would be looking after vulnerable children.

4.439 Staff do not appear to have been adequately trained during this period.

4.440 In practice, corporal punishment was banned and restraint only permitted in exceptional circumstances, according to the evidence.

4.441 By 2005, Heathfield was "failing" and had been struggling for a long time, with a litany of concerns raised by others and significant criticisms made of Kevin Parr-Burman's management of the Home. We consider that the response to this, which included Kevin Parr-Burman blaming the young people for not engaging, and Joe Kennedy emphasising the necessity of control as opposed to care, was inappropriate. Blaming the children, even in part, shows, in our view, a lack of insight into the responsibility of those in charge.

4.442 The governance of the Home during the 1980s and 1990s appears to have been minimal, with no unannounced inspections and only sporadic visits from social workers. The involvement of Children's Services and the relevant Committees in the response to allegations of abuse in the late 1980s, early 1990s, the 2000s, is dealt with in Chapter 9.

[546] Day 69/171–173

La Preference: a Private/Voluntary Home (1951–1984)

Organisation and management

4.443 Flora Walden ran La Preference from its inception until her retirement in 1971. An obituary written by Patricia Thornton in 1989 describes Flora Walden's *"wonderful flair with children of all ages"* and how she *"really understood how children felt and considered each one's individual needs".* It was thought that Flora Walden has *"pioneered in Jersey the family group approach to child care"* that she was a "*pioneer in residential child care".*[547]

4.444 Christine Wilson then ran the Home from 1971 until 1983,[548] after having been a resident staff member from 1968. She had no real training or experience but in the mid-1970s she attended training sessions organised by Children's Services: for example, "Problems in adolescence" and "Child abuse in the family". Her husband was not formally a member of staff but was expected to play the role of Housefather when he returned home from work.

4.445 According to Christine Wilson, they advertised locally for staff and although it assisted if applicants had relevant background experience, there were no minimum requirements and no qualifications necessary. It would appear that there was a policy of generally recruiting "live in" staff who were vegetarians, however this was changed in 1975.[549] According to Christine Wilson, at all times the other staff were not vegetarian.[550] Christine Wilson would interview applicants along with Maxwell Lee, while the Children's Officer would only be involved to run checks on names.[551]

4.446 The residents at La Preference were a mixture of children in the care of the Education Committee, those admitted by the Connétable and those placed privately. Even before it was registered as a Voluntary Home from 1970, residents had an appointed CCO. for example in 1967, a Ms Preece was

[547] WD004284/4

[548] Apart from a short period in 1975 when she was considering moving to New Zealand, but was asked to return: Day 96/28–29

[549] Day 96/20, 29

[550] Day 96/20

[551] WS000626/15

responsible for 12 children at La Preference.[552] This mixture of admissions continued following the introduction of the *1969 Law* – according to Christine Wilson, who joined the staff in 1968, the children at La Preference all came via Children's Services, although some were not formally "in care" and their parents would pay for their care directly,[553] although Christine Wilson's views as to the suitability of the child would not be sought, she was given the child's background.[554]

4.447 From the late 1970s onwards La Preference received more children from Haut de la Garenne. Some exhibited serious behavioural difficulties and had struggled to settle at other homes. Christine Wilson told the Inquiry that "*these children had a real impact on the behaviour of the existing family of children at La Preference*". In evidence, she gave an example of the child, placed in the late 1970s, who needed more specialist help and on one occasion threatened to kill a policeman.[555]

4.448 The Lambert and Wilkinson Report in 1981[556] noted that when Christine Wilson and her husband were at La Preference at the weekend, they were placed under "*considerable strain*". The Home had accommodation for 20 children aged from birth to 20 years old; as at March 1981 16 children were in residence. Despite the age range identified in the Report, the Chair of the Vegetarian Society noted that there was "*no pressure exerted to make children leave when they reached a particular age*".[557] Christine Wilson recalled that they "*often had more than twenty children staying at the Home at any one time*".[558] She thought that the staff ratio was generally 1:4 or 1:6[559] and Ernest Mallett (staff member) recalled that Christine Wilson was effectively on duty all of the time.[560] On reflection, Christine Wilson considered

[552] WD005585
[553] WS000626/3
[554] Day 96/34
[555] WS000626/17; Day 96/36
[556] WD004129
[557] WD004119; oldest resident then 22 years old
[558] WS000626
[559] Day 96/23
[560] WS000602/11

that staffing levels were too low but that had to be balanced against her view that too many staff could destroy a family atmosphere.[561]

4.449 Christine Wilson's approach to discipline was informal – children were sent to their room or given a smack on the bottom (for younger children) over the clothing. Older residents were grounded as punishment. She recalled only two incidents in the late 1970s when WN583 used a bamboo cane on the hands of a child. She described these incidents as exceptional and different to the minor problems otherwise experienced. She said that she would never advocate children being hit, but accepted that at that time it was probably the accepted form of severe punishment.[562] No violent behaviour was reported to her by the children[563] and she "*did not witness any form of abuse*".[564]

4.450 There were no written policies or guidance on discipline and according to Christine Wilson, matters were discussed informally in the mornings.[565]

4.451 Christine Wilson decided to leave La Preference in 1983, partly for personal reasons and also partly due to there being more difficult children living at the Home than there had once been.[566] Following a period of instability with three different people in charge between July 1983 and March 1984, it was decided that the Vegetarian Society (later to become the Vegetarian Charity) would no longer run La Preference (as above).

Culture

4.452 Christine Wilson told the Inquiry that during Flora Walden's time, the atmosphere was that of "*a very loving environment*" in which there was "*very little bad behaviour*".[567] She is described as being firm and ensuring that children were aware of the boundaries, but she did not shout and was driven to make La Preference as homely as possible.

[561] WS000626/19
[562] Day 96/59
[563] Day 96/60
[564] WS000626/20
[565] WS000626/13
[566] WS000626/18
[567] Day 96/18

4.453 Christine Wilson's philosophy was that she wanted children to view La Preference as their home. They were afforded a degree of trust and freedom; fewer rules and a more relaxed environment than in Homes run by the States. She said: *"Personally, all that I ever aimed to be was a substitute mother, not a replacement mother but someone who could show children … love and affection".*[568]

4.454 Ernest Mallett, who arrived in 1982, also found the Home to have a "*family atmosphere"* that ran in a relaxed way and worked well. This concurs with the Lambert and Wilkinson report in 1981, which noted "*The atmosphere at the home is certainly one of a large, but happy and sometimes chaotic family*".[569] They noted that although some incidents of misbehaviour were reported, the general impression was that children find the atmosphere a settling one and receive a caring experience. Discipline at La Preference was described by one member of staff as "*firm".*[570]

4.455 On reflection, Christine Wilson said that children at the Home were more stable in the early years when, under Patricia Thornton, the approach was to place children at La Preference for medium to long-term care. However, this shifted to an approach of trying to ensure that children were returned to their families as soon as possible, which Christine Wilson said that she could understand but thought was less successful in keeping children settled.[571]

4.456 The residents' perspective on the Home is reflected in the following accounts:

4.456.1 WN212 (admitted 1954, aged three) described Flora Walden as a "*lovely woman*" who was interested in the children; he said that they were quite a "*happy band of children*".[572]

4.456.2 WN201 (1971–1980) describes the Home as strict but fair, it was "*generally fine*" and he was better off there than with his mother.[573]

[568] WS000626/20
[569] WD007382
[570] WD007382/64
[571] WS000626/8
[572] Day 54/41
[573] WS000430/5

4.456.3 WN617 stated that the Home was a nice place when run by the voluntary sector but deteriorated once the States of Jersey took over.[574]

4.456.4 WN214 (resident from 1977) describes a feeling of worthlessness. "*The warmth comes from the people sharing their love, being with the children. This never happened*".[575]

Governance

4.457 When run as a Voluntary Home, La Preference was overseen by the Vegetarian Society in the UK. Christine Wilson recalls that when Maxwell Lee took over as Chairman of the Society in about 1970, he visited four times a year for a week at a time; he was interested in the welfare of the children.[576] Prior to that the focus, she thought, was more on finance and administration rather than the children's welfare, although members of the Society would visit the Home, particularly at Christmas. In April 2008, the SOJP spoke to an Ian Jeffries, who was a Committee member of the Vegetarian Society and came over to La Preference on his own on four or five occasions to see how the money was being spent, during which he would spend time on a one-to-one basis with some of the children. He said that none of the children ever told him about any abuse suffered, of any nature.[577]

4.458 Christine Wilson would write general reports on the Home for the Vegetarian Society, but these would not be on individual children.[578] They kept some records in respect of each child (such as school reports and medical issues), but they were not official records. The child's file was kept by Children's Services.[579]

4.459 In March 1975 (during the brief period when Christine Wilson had left her role in charge of the Home), a member of the Children's Sub-Committee raised

[574] WS000436/2
[575] WD000670
[576] Day 96/15
[577] WD006378
[578] Day 96/20
[579] Mrs Wilson, Day 96/38

concerns about the care of the children. The Children's Officer, Charles Smith, responded that he had visited the Home and identified the difficulty as being caused by inexperienced staff and "*the inability of the Governing Body of the Home to recruit trained staff who were also vegetarian*".[580] A month later the problem was resolved when La Preference agreed to recruit staff who were not necessarily vegetarian. The Committee noted that "*a minimum of four childcare staff were employed for the twenty children resident there".*[581]

4.460 At the same time, it was recorded that Charles Smith had been invited to attend the AGM of La Preference in London and had accepted the nomination to be Vice President of the Home (showing a similar degree of Children's Services involvement as with Brig-y-Don). He had also agreed to help establish a local Committee to help administer the Home.[582] By 1981, it was noted in the Lambert and Wilkinson Report that there was a local executive committee.[583] Christine Wilson thought that before this local Committee was set up, Children's Services were not that concerned with La Preference, to the extent that in hindsight, she was surprised that they had been placing children there.[584]

4.461 Christine Wilson recalls that two or three Child Care Officers visited the Home every week, usually without prior notice. This was the main part of Children's Services oversight according to her. Although she had contact with Charles Smith there were no formal meetings with him or members of the Education Committee.[585] Lambert and Wilkinson noted in 1981 that there was no formal review system.

Findings: La Preference: a Private/Voluntary Home (1951–1984)

4.462 There is little evidence about the running of the home during the 1950s and 1960s when Mr and Mrs Walden were in charge. Patricia Thornton described Flora Walden as having pioneered the family group approach to child care in

[580] WD004114
[581] WD004115
[582] WD004115
[583] WD004129
[584] Day 96/18
[585] WS000626/11

Jersey. Staff noted no abuse or cruelty and described it as a *"very loving environment".*

4.463 The organisation and management of La Preference during the period from 1971 to 1983 was largely adequate; however, this was primarily due to efforts of Christine Wilson, who worked with very little, if any, time off. This was particularly the case towards the end of the period, when the Home began accepting more children from HDLG, who tended to pose difficulties for staff. For most of the period, Christine Wilson's husband was not formally a member of staff but was expected to play the role of Housefather when he returned from work – a situation akin to that which existed in Family Group Homes.

4.464 Insufficient staffing levels meant that Christine Wilson and her husband were under "considerable strain". Recruitment criteria were not strict and no qualifications or minimum requirements for background experience were in place, although until 1975 it would appear that "live-in" staff were only recruited if they were vegetarians. Most staff, including Christine Wilson, had no real training or experience when they began working at La Preference. Christine Wilson at least attended some training sessions organised by Children's Services in the mid-1970s, but we suspect that the general lack of staff training was another consequence of the lack of proper oversight noted below.

4.465 During this period, there was an informal approach to discipline, with caning described as "exceptional" by Christine Wilson and methods such as grounding the child more common. There were no written policies or guidance for staff. We consider that in fact, the approach to discipline was adequate and progressive, but one of the consequences of the lack of oversight was that there were no guidelines or rules, which was not an adequate state of affairs.

4.466 The evidence suggests that during this period, the Home had a family atmosphere and a more relaxed environment. Christine Wilson tried to be a "substitute mother" and this appears to have had a positive effect on the culture of the Home.

4.467 Although the Inquiry did not review the records of the Vegetarian Society, they appear to have maintained some governance of the Home but were not particularly concerned with the welfare of the children.

4.468 From 1969/1970, the States of Jersey took on a supervisory responsibility for the Home. A local committee of the Vegetarian Society was established in the mid-to-late 1970s and Children's Services were more involved from then. Prior to this point, the lack of interest shown in the Home by Children's Services is concerning – given that they were placing children in care in the Home, they should have taken more responsibility for ensuring that standards were adequate.

La Preference: run by the States of Jersey (1984–2012)

Organisation and management

4.469 The number of residents varied in this period from nine in June 1985, to 14 in October 1988 and December 2002, and then down to 12 in March 2004. According to Ernest Mallett, when the Home transferred to States ownership there was a turnover of residents as they tried to rehouse as many as possible with their families before those from HDLG moved across.[586] There was a need for stricter procedures to accommodate these children as they had "*more behavioural issues*", said Ernest Mallett. He thought that the challenges grew in the absence of any training on restraint, which was only received in 2000. There was no training on dealing with children misusing drugs.[587]

4.470 Fay Buesnel (now deceased – former Matron at HDLG) was Officer in Charge from the beginning of this period. She remained in post for 15 years.[588] A number of staff moved across from HDLG and existing staff had to re-apply for their jobs.[589] According to Ernest Mallett, staff recruitment was discussed

[586] WS000602/17
[587] WD006090
[588] WD00691/6
[589] WS000602/

between Fay Buesnel and himself but they were unable to recruit without reference to Children's Services.[590]

4.471 Ernest Mallett said that staff meetings were held each week and "key worker principles" implemented in a "*more formal fashion*".[591] If a child had to be restrained, the fact was recorded in a log; if the matter was serious the CCO would be informed.

4.472 WN283 moved to become a member of staff at La Preference and recalled how much better it was run than Clos des Sables (her previous role); there were regular staff meetings, all staff were involved in discussions about child care, and there was an organised filing system.[592]

4.473 Fay Buesnel left in 1999 and WN687 was appointed Officer in Charge (a role he carried out until 2003). A "Home Statement"[593] was created[594] which set out a list of objectives including:

4.473.1 *"to identify each child's physical, emotional and social needs and to work with children to arrange appropriate care experiences or programmes; and*

4.473.2 *to properly prepare young people for independent living".*

4.474 WN687 and his Deputy managed the Home with a further six residential CCOs who had a variety of qualifications, and most of whom had extensive experience. They were supported by a cook, cleaning staff and five night supervisors.

4.475 The "Home Statement" set out the procedure for drawing up care plans, holding planning meetings and holding internal case reviews. It directed that the SOJP be informed within two hours of a child's expected time of return if they went missing, or immediately if considered vulnerable and at risk. The Statement also advised that children who wished to complain should in the

[590] Day 81/174
[591] Day 81/174
[592] WS000725/17
[593] A requirement of Part II of the Children's Home Regulations 1991
[594] WD009233

first instance tell "*the member of staff they trust most*", WN687 or their CCO, failing which they should tell their teacher, parent or the Children's Officer.

4.476 A document entitled "Sanction Book Guidance" set out rewards for positive behaviour and sanctions for negative behaviour: for example, mobile phone confiscated, *"grounded*" or "*home visits cancelled*".[595]

4.477 WN687 gave a statement[596] to the SOJP in March 2009 and highlighted the following about his time at La Preference:

4.477.1 he was constantly *"badgering*" the States for more staff and more therapeutic input for the children; he was not given what he requested and ended up "*falling out*" over the money situation;

4.477.2 by 2002/2003 the numbers increased and at one point there were 18 in the unit rather than the agreed 10 that were there when he started;

4.477.3 some of the children admitted should have been on remand – there was no behavioural management of the children.

4.478 During this period, Ernest Mallet recalls that if they wanted to take children out, they had to undertake risk assessments and other things which in practice meant that the frequency of such trips reduced significantly.[597] Ernest Mallett describes WN687 as having an attitude problem and thinks that he did not listen to staff, as well as having brought in a number of new rules that restricted the running of the Home.[598] Examples of this are that a ratio of one adult for two children was imposed when taking children out. On reflection in his evidence to the Inquiry, Ernest Mallett thought that, although there had to be a balance between protecting staff and allowing the children flexibility, there was a loss of family atmosphere in general when the States took over the running of La Preference and there was not the same sense

[595] WD005599
[596] WD005343
[597] WS000602/18
[598] WS000602/22

that the staff truly cared about the children.[599] Ernest Mallett did accept that it probably was not realistic to expect that atmosphere to continue given the challenges that Children's Services were facing.[600]

4.479 By March 2007, the unit was being run by an individual who described himself as a qualified social worker with specialist skills in human rights advocacy.[601] In August 2009 Kevin Parr-Burman became Manager, having moved from Heathfield after an allegation of assault made by resident there. In August 2010, he left La Preference after another allegation of assault was made against him. During the disciplinary investigation in relation to the alleged assault at La Preference, he described the management and organisation during the year he spent there:[602]

4.479.1 he was supervised monthly by his Line Manager, Joe Kennedy;

4.479.2 he was a qualified social worker, who had worked in children's services since 1978 and in secure units in the UK for 15 years before moving to Jersey in 2004;

4.479.3 he was trained in therapeutic crisis intervention (including a refresher course) and also in General Service Training (GST). He noted that the latter would not be appropriate in a children's home and would only be used in a secure unit;

4.479.4 his role was to manage the unit, the budget and staff; and to ensure that care plans were up-to-date. Occupancy lists were completed each day by staff "running reports" were completed as soon as possible;

4.479.5 in the summer of 2010 they had six or seven residents; two or three staff on duty during the day, and one sleeping and one waking member of staff at night;

[599] WS000602/28
[600] Day 81/171
[601] WD005844/107 – we have little other evidence from this period
[602] WD009059/24

4.479.6 on arrival at the Home, residents were given a Young Persons Handbook[603] which included behavioural expectations and what happened in the event of misbehaviour. This would be explained and discussed with the young person.

4.480 In an exit interview from April 2012, Kevin Parr-Burman made the following points:[604]

4.480.1 staffing of residential units in Jersey was far below UK standards;

4.480.2 training opportunities were very limited;

4.480.3 despite criticism of the management of Children's Services arising out of the Historic Abuse Inquiry, the same people remained in place and thus nothing was likely to change;

4.480.4 he had not received good supervision in comparison with that received in the UK;

4.480.5 children's services, particularly residential services, were run on a "blame culture" and staff were not supported by management. Any efforts to bring in change were seen as interference and morale was very poor, with staff being moved around regularly in disregard for their individual choice and the needs of vulnerable young people;

4.480.6 he had been subject to *"malicious complaints"* by residents, the management and investigation of which had been very poor.

4.481 When these points were put to Phil Dennett in evidence, he agreed with Kevin Parr-Burman about the insufficiency of staffing, but disagreed with the other points.[605] We do note these comments in the context of the allegations of assault made against Kevin Parr-Burman in 2008 and 2010.

[603] E.g. WD009368

[604] WD009174

[605] Day 134/84–91

Culture

4.482 The following evidence from former residents provides some insight into the culture at La Preference across the relevant period:

4.482.1 WN3 went to La Preference right at the beginning of the period when it was run by the States of Jersey (1984). She described the staff as really nice, although she said the Matron was quite strict. She says she would go to the youth club, get taken to fetes and go on camping trips while at the Home and really enjoyed her time there.[606]

4.482.2 One child went to La Preference in 1992 when she moved out of the Blanche Pierre Family Group Home.[607] It was noted in a report dated 27 February 1998, prepared for the intended prosecution of Alan Maguire, that her move to La Preference made her realise that it was possible to be treated differently (from the way she was treated at Blanche Pierre) and she considered the staff at La Preference to have time to listen to any problems.[608]

4.482.3 WN73 was in La Preference in the early 2000s and described the Home as being "alright", stating that it had much more of a family feel (than Les Chênes). He says that it was quite nice but his problem there was that he never had his own room and, for most of his time there, stayed on a put-me-up bed in the chill-out lounge.[609] In his oral testimony, WN73 said that the staff were a lot more friendly at La Preference and actually wanted to help the children. He said *"they were more interested in your life I think as opposed to containing you. You were treated I feel with a lot more respect* […]".[610]

[606] WS000470
[607] WD001095/60
[608] WD001082/31
[609] WS000443/6
[610] Day 56/48

Governance

4.483 La Preference was a States run children's home during this period with governance provided over the years by the Children's Sub-Committee, the Education/Health and Social Services Committee, the Minister for Health and Social Services and the Children's Executive.

4.484 Dr Kathie Bull's 2002 Report noted that La Preference (as with Heathfield) was often more than 40% over-occupied and had an inadequate number of staff. Criticisms were made about the level of staff training and expertise, the lack of external monitoring and the weak case planning. There was also the difficulty of separating younger children "*whose behaviour might be affected or worsened by the presence of older children*".[611] The Report did praise staff commitment and their effort to foster good relationships with the children.

4.485 Ernest Mallett was surprised that he was not spoken to by Dr Kathie Bull, despite having worked at La Preference for nearly 20 years. He agreed with the criticism of staff competency and training, and said that there was overcrowding to the extent that, towards the end of his time at La Preference (around 2002/2003), children were sleeping downstairs in the living room.[612]

4.486 By the time of the Williamson Report in 2008[613] and the Coordination of Services for Vulnerable Children Sub Panel Review in 2009,[614] La Preference was regarded more positively.

Findings: La Preference: run by the States of Jersey (1984–2012)

4.487 The organisation and management of the Home was largely adequate during the period in which Fay Buesnel was in charge (up to 1999). Staff meetings were held each week, restraint logs were kept and key worker principles were implemented.

4.488 During the early 2000s, the organisation and management of the Home appears to have deteriorated, although this may be, at least partly, due to

[611] WD004106/363
[612] WS000602/25–26
[613] EE000070/13
[614] WD006407/7

governance failings. While the Home Statement from the early part of this period properly recognises the importance of identifying the needs of each child and preparing them for independent living, as well as providing guidance for residents to complain, this period was characterised by insufficient funding and overcrowding. The Home was often more than 40% over occupied, had insufficient staffing levels and the staff that were there were insufficiently skilled or trained, despite their commitment and efforts to foster good relationships with children. At some points, children were sleeping downstairs in the living room. This is an unacceptable way for a Home to be run in the 21st century and reflects poorly on the governance in place at the time.

4.489 When the Home was run by Kevin Parr-Burman, there does appear to have been supervision and attempts to recruit experienced and trained staff. However, Kevin Parr-Burman later described this supervision as comparably poor and said that staffing levels and training were below UK standards.

4.490 In terms of culture, the Home was run more strictly than when it was a Voluntary Home, with an increase in procedures and policies that staff had to follow. This may have led to a loss of a family atmosphere, however we think that overall this was likely to be a positive change and showed that the Home was, at least to some extent, moving with the times – for example, imposing staff to children ratios when taking children out of the Home. Although we note the allegations of abuse during this period (as discussed in Chapter 9 below), we consider that the culture remained generally positive, largely because of the willingness in staff to listen to the residents and try to help them.

4.491 We consider that failings in governance are likely to have been responsible for the situation in which the Home found itself in the early 2000s. Later reports from 2008 and 2009 suggest that the position subsequently improved.

Brig-y-Don: a Private/Voluntary Home (1934–2009)

Organisation and management

Residents/admissions

4.492 The Inquiry conducted an analysis of the number of children in residential care at Brig-y-Don from 1969 to 2000,[615] which showed a sustained drop in numbers from the 1980s onwards. This corresponded with an Education Committee decision to prioritise placement in States owned Homes for financial reasons in the early 1980s.[616] A brief rise in numbers occurred between 1982 and 1987 alongside the decision to close HDLG, with the Director of Education emphasising the need to develop a stronger link with independent children's homes.[617]

4.493 Margaret Holley said that, during her time in charge (1973–2004), admissions were generally either, (i) by the States of Jersey, or (ii) under private placements agreed between the child's family and the Home. The private placements would typically be of short duration and a CCO was not assigned to the child. Private placements were often arranged by the family doctor, on the basis that the parents paid.[618] By the mid-1980s, residents were almost entirely placed by Children's Services; staff and children were better supported and Brig-y-Don received a payment per child per day in the initial period.[619] By the late 1980s/1990, funding was via an annual grant in order to make planning easier.[620] According to Margaret Holley, the amount of information given about children being admitted varied and they did not have much discretion to refuse the admission of a child for whom there was a vacancy.

4.494 When Margaret Holley's period in charge began, the children were mostly of primary school age and the Home's expertise was with younger children. She

[615] WD005072
[616] WD005018
[617] WD005014
[618] WS000575
[619] Day 68/49; Margaret Holley, Matron 1973–2004
[620] WS000575/7

thought it was regrettable when children had to stay at Brig-y-Don rather than being fostered and also saw the value of children transferring to Haut de la Garenne, as they catered more for older children. In her view, those children who had a good attachment to their own families managed very well at Brig-y-Don.[621]

4.495 In 2000, two of the children who subsequently became involved in the "X Children" litigation,[622] were placed at Brig-y-Don. The Plaintiffs' expert, Maria Ruegger, noted that the practice of using residential care for this age group (four and under) was significantly out of step with practice in the UK. The Defendants' expert, Stephen Pizzey, noted the children of that age would ordinarily be cared for in foster care as placement of such young children in a residential setting with regular staff changes would likely lead to more problematic behaviour. He noted however that in Jersey at that time, placement of young children for rehabilitation in Brig-y-Don was standard practice.[623] Elsewhere, the presumption was against placing young children in residential care. By 2005, Brig-y-Don had refused to admit a child due to their view that "*it was not the right admission",* they were under no obligation to do so, and they did not want to disrupt their present children.[624]

Staffing

4.496 Patricia Thornton considered that, in 1971, *"present staffing arrangements were unsatisfactory*" and insisted upon the appointment of a Deputy Matron to bring the complement up to five.[625] In 1972, a further nursery nurse was added and the Home catered for 14 residents and 10 day-care children.[626]

4.497 When Margaret Holley became Matron in 1973, after being interviewed by the Brig-y-Don Committee and Charles Smith (Children's Officer), she had no formal qualifications. She was NNEB trained and had extensive experience

[621] Day 68
[622] Recent litigation on behalf of children against the States of Jersey
[623] WD008980
[624] Day 68/10
[625] WD004856
[626] WD0048

working in a nursery and as a nanny.[627] During her time in charge (she retired in 2004), she had sole responsibility for recruitment of most positions, albeit Children's Services had oversight by virtue of their involvement in the Brig-y-Don Committee. Margaret Holley viewed previous experience as the most important quality in potential staff and qualifications would be an added bonus.[628] Margaret Holley said that a staff/children ratio of approximately one to two and the key worker/co-worker systems were important elements in the Home's success.[629]

4.498 Margaret Holley did recall that members of the community would sometimes, around Christmas, get in touch about helping with the children or getting to know them. However, she said "*there was absolutely no way we could do that. We would always refer anyone who felt they could help to the Children's Services".* We note that this appears to have been a different approach to that taken in HDLG.

4.499 Margaret Holley recalled that during the early period there was little recorded information about the children and information was passed between staff orally.[630] WN503 was recruited from HDLG and brought an insight into the way a care home was run by the States of Jersey, as opposed to Brig-y-Don's "charity focus", and was described as the driving force in the 1990s for the Home's progress in updating and developing child care practice, introducing paperwork/audit trails.[631] Margaret Holley recalls that on occasions where they were understaffed, other staff would usually be flexible. She believes that "*the low turnover of staff at Brig-y-Don meant that children were provided with continuity".*[632] Margaret Holley opined that it was very valuable having these core members of staff who really cared and knew the children well.[633] There were regular staff meetings and a system of supervision evolved. In the 1990s

[627] WS000575/2
[628] Day 68/55
[629] Day 68/79
[630] Day 68/89
[631] WS000575/10
[632] WS000575/11
[633] Day 68/47

Margaret Holley was supervised by someone within Children's Services, generally the Children's Officer.

4.500 Specific training was not given to staff but they were invited and delighted to attend training organised for the States-run children's homes. Examples of the type of training/advice received included:

4.500.1 how to spot signs of children who were sexually abused and how to communicate with them;

4.500.2 National Children's Home training programme in 1989;

4.500.3 fostering course to facilitate work with families managing the transition;

4.500.4 targeted training on ways to deal with challenging children.[634]

4.501 Margaret Holley noted that there were *"limits to the training and qualification of staff at Brig-y-Don"*, which meant that they had to obtain external support as much as necessary, for example when medical issues arose.[635] Margaret Holley was protective of her staff and wanted them to work within the limits of their training and not beyond.[636] In the absence of training, Ms Holley recalled that the staff would "*communicate a lot and discuss different situations, so that people were comfortable with the children they were seeing to".*[637]

4.502 As noted in Chapter 3 on the type and nature of the Home, in the late 1980s and early 1990s Brig-y-Don was closely involved with Children's Services' "shared care" scheme, whereby children would be able to maintain regular contact with their family while spending time at the Home during the week. An "outreach" service was also provided, which aimed to support families in their own home and support children after they had left Brig-y-Don. This outreach

[634] Training provided by Pat Curtis
[635] WS000575/15
[636] Day 68/70
[637] Day 68/63

work would usually be done by the relevant "key worker" and it was noted in 1994 that there were "*five children on outreach".*[638]

4.503 The "key worker" system was introduced in the 1990s[639] which allowed a child one-on-one time with an assigned member of staff. It also assisted the transition into independent living or foster care when they left. A system of co-workers provided a secondary dedicated person for the child if the key worker was not available. The system ran in parallel with the child having a CCO.[640] Both had the "*same goal of the child being happy*".[641]

Culture

4.504 Margaret Holley told the Inquiry that she considered it the Home's ethos for staff to be as "*friendly, helpful and caring*" as possible.[642] It was important to ensure that the Home was not institutionalised while establishing a routine to make children feel secure.[643] She acknowledged that one could never replace the family home and said that with small children one would not aim to do that, but felt that they should aim to make it comfortable and to have a warmth about it.[644]

4.505 Discipline was described by Margaret Holley as a *"firm but fair*". There was no beating or caning, and there were no detention rooms.[645] In the initial period, discipline was left to the judgement of those running the Home rather than directed by Children's Services or the Committee. This approach changed by the 1990s with Children's Services advising that there should be no physical contact, and the approach changed to attempts to defuse situations and revoke privileges as punishment.[646] She was trained in restraint by Pat Curtis, but this was rarely used.

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[638] WD005488/107

[639] By which time it had already been implemented at Heathfield

[640] Margaret Holley recalled regular visits, with the child taken off the premises – Day 68/75

[641] Day 68/74

[642] Day 68/26

[643] WS000575/19

[644] Day 68/33

[645] WS000575/23

[646] WS000575/24

4.506 In the 1990s Margaret Holley introduced children's meetings which allowed residents to make their views known if they considered something unfair.[647]

4.507 A lot of children were only resident in Brig-y-Don for a short time, often when they were very young. As a result, although we received evidence from a large number of children who attended Brig-y-Don during this period, many of them did not give evidence about their time at the Home. Notwithstanding this, the residents' perspective on the culture of the Home is reflected to some extent in the following accounts:

4.507.1 John Doublard attended just before the Second World War and then later in the 1940s. He told the Inquiry that Brig-y-Don "*was for me a home from home".*[648]

4.507.2 WN118 (resident at the end of the 1950s) said that the staff were nice.[649]

4.507.3 WN23 (resident in 1979) said it was "*a great place for children*", close to the sea. Staff were strict about meals; she had to sit and finish a meal after everyone had left. Generally, she had very happy memories.[650]

4.507.4 WN3 (resident for two years in the 1970s) stated that staff were "*really nice"* and she would like to have stayed at Brig-y-Don long-term.[651]

Governance

4.508 Brig-y-Don was overseen by a Committee during its time as a Voluntary Home and Margaret Holley said that she was answerable only to them.[652] The membership, according to her, tended to be "*pillars of the community*" from a range of professional backgrounds, and included a representative of

[647] Day 68/337
[648] Day 22/54
[649] WS000540
[650] Day 20/18
[651] Read in on Day 57
[652] WS000575/3

Children's Services. Meetings were monthly and held at the Home. Margaret Holley presented short written reports about the Home and then expanded on this orally; the Committee prepared annual reports.[653]

4.509 Although the Committee had overall responsibility for the Home, Margaret Holley recalled that if there were any concerns about a child then they would raise this with Children's Services. They did so on two occasions in particular due to suspicions of abuse in the family home.[654] Each child would also have a CCO, who would visit and spend time with the child.[655]

4.510 There was a period in the early 2000s in which the financial viability of Brig-y-Don was in issue due to the growing preference of Children's Services to place children under the age of 11 in foster care rather than Brig-y-Don.[656] However, Margaret Holley and others on the Brig-y-Don Committee felt at that time that there was still a need for Brig-y-Don due to the insufficiency of foster placements.[657]

Findings: Brig-y-Don: a Private/Voluntary Home (1934–2012)

4.511 During Margaret Holley's tenure as Matron of Brig-y-Don, the management and organisation of the Home were adequate. Brig-y-Don succeeded as a children's home largely because of the leadership of Margaret Holley. To her credit, she kept pace with the thinking elsewhere, and maintained a high staff to child ratio. In the late 1980s and early 1990s, the Home was at the forefront of shared care, outreach and key worker schemes, which helped to focus on the individual child and to maintain close contact between children and their families. WN503's recruitment helped to drive progress in developing child care practice at the Home.

4.512 Recruitment was largely the responsibility of Margaret Holley, although the Brig-y-Don Committee, in which Children's Services played a role, was also involved. Qualifications were seen as a bonus and previous experience was

[653] WS000575/5
[654] WS000575
[655] Day 68/75
[656] WD005488/40
[657] Day 68/553

seen as the most important quality. Although they were sometimes understaffed, staff turnover was low due, no doubt, in large part to the culture of the Home. A system of supervision evolved and Margaret Holley herself was supervised by someone within Children's Services, despite Brig-y-Don's status as a Voluntary Home. We think that the approach to supervision and recruitment was adequate for the standards of the time.

4.513 Staff attended training sessions run by the States of Jersey and Margaret Holley encouraged discussion between staff. We consider that this was largely adequate in itself, and think that Margaret Holley's insight as to the limits of the training and qualifications of her staff was a positive thing. This ensured that they would obtain external support when necessary.

4.514 The placement of young children under four years of age in residential care at Brig-y-Don up to and during the 2000s was not an adequate policy according to the standards of the period under review. It was "*significantly out of step with practice in the UK"* according to Maria Ruegger.[658] Children of that age in the UK were usually placed in foster care. However, we note that any fault does not lie with the management of Brig-y-Don, and that a likely cause for these placements was the lack of available foster parents – a problem which we discuss in Chapters 2 and 3.

4.515 On the basis of the limited evidence available to us, we find that the culture of the Home was generally a positive one, with a friendly and warm atmosphere. Discipline was left to the judgement of staff and was "firm but fair", and the approach to discipline progressed in line with practice elsewhere in the 1990s.

4.516 On the basis of the evidence of Margaret Holley, children were provided with the opportunity to raise complaints in the 1990s. We consider that this was a positive step and in line with the developing position in the UK at the time.

4.517 Governance of Brig-y-Don during this period was adequate. In comparison to the other major Voluntary Homes at this time, La Preference, Brig-y-Don had a Committee that appears to have provided proper oversight of the children in

[658] Consultant Guardian and Social Care Expert

its care. Annual reports were prepared by the Committee, and Margaret Holley reported to them on a regular basis as to the welfare of the children.

4.518 By the mid-1980s, a large proportion of children at Brig-y-Don were placed there by Children's Services, and we note that they retained some oversight of the Home. A representative from Children's Services was on the Brig-y-Don Committee, they would be involved if there were any concerns about a child at the Home, and each child had a CCO who would visit and spend time with them. We consider that the involvement of Children's Services in the governance of Brig-y-Don was adequate.

Brig-y-Don: run by the States of Jersey (2011 to present)

4.519 The Inquiry did not hear oral evidence from any witness who was resident or who worked in Brig-y-Don during this period. As a result, our analysis is based on documentary evidence, as well as the oral evidence of Phil Dennett, who held an oversight role at that time.

4.520 As noted in Chapter 3, in June 2011 Brig-y-Don re-opened as a small six-bedroom unit run by the States of Jersey, taking the young people previously resident at Heathfield. Admissions were by application of the allocated social worker to the Placement and Resource Panel, or in an emergency, to the Manager of Residential Secure Services. Children were provided with a Children's Guide and an information pack prior to arrival. An induction period of four weeks followed with an assessment of needs completed within the first two weeks.[659]

4.521 In the "Statement of Purpose and Function" for Brig-y-Don, dated May 2013, the staffing structure is set out, noting that there should be one or two care staff on duty at any one time.[660] The Manager and/or Senior Shift Leader was responsible for running the Home. The qualifications and experience of the 12 care staff are set out, and we note that the vast majority have many years' experience working with children and young people.[661]

[659] WD009223
[660] WD000729/7
[661] WD008729/13

4.522 In October 2012, there were three children in Brig-y-Don House and one child with "*multiple emotional and physical problems*" in one of the flats. The Board of Visitors noted in their annual report: "*despite all its obvious advantages Brig-y-Don does not appear to have the feel or the same happy relaxed atmosphere that the smaller homes … appear to have achieved … The larger size, wider age range and staff changes may have contributed to this. The staff are friendly and professional and do their best to deal with some challenging behaviour".*

4.523 In June 2013, the SOJP noted that a recent increase in "*missing persons*" reports from the Home was partly due to an SOJP directive (about how things were logged) as a result of concerns about child sexual exploitation.[662] Phil Dennett, (Manager of Children's Services), told the Inquiry that Children's Services were a key partner agency in Operation Vessel.[663] One of the ways they were addressing sexual exploitation of children in care was by responding immediately when someone went missing. He thought that the reason for absconding at Brig-y-Don was due to a combination of factors. This included lack of stability and good relationships that provide emotional attachment for young people.[664] At this time, serious concern was expressed by the Honorary Police about the control of a number of young people housed at Brig-y-Don.

4.524 In October 2013, there were six residents described by the Board of Visitors as "*challenging in their individual ways*". The annual report expresses concern about "*a lack of leadership … Staff being at a loss to know how best to deal with the many challenging situations that arise. We feel that the culture of the home needs to change in order to provide a suitable environment for the (young person) to grow and develop*".[665] They noted that the Home had "*the character of a turbulent Children's Home"* despite the staff efforts and the fact that facilities were of a high standard. There was a large turnover of residents, which led to a lack of community feeling between them. Several of the

[662] WD009031

[663] A 2013 investigation into allegations of child sexual exploitation of 12 girls aged 12–16

[664] Day 134/121

[665] WD009019/17

residents were waiting for suitable foster placements, making it difficult for them to remain positive.

4.525 In November 2013, an email from the Health and Social Services Health and Safety Manager noted 127 reports[666] (dating back to 2011) reported on Datix,[667] which had not been investigated. In total, there were 47 reports in 2012 and 135 reports in 2013.[668] These reports consisted of requests for police attendance, occasions on which physical restraint was used, and incidents of violence and aggression In evidence to the Inquiry Phil Dennett said that he thought that investigations were undertaken but the managers were not "*signing off*" electronically.

4.526 In a meeting between Phil Dennett and the Manager of Brig-y-Don in March 2014, Phil Dennett expressed "*great concerns regarding Brig-y-Don*".[669] These included: "*children absconding, an increase in the use of restraint and challenging behaviour by young people".*[670] He acknowledged that the situation was complex, but noted that other outside agencies in addition to the Board of Visitors had expressed their concerns about the situation at the Home. During this meeting, Phil Dennett explained that the Manager would be moved into a different team and that Joe Kennedy would go into Brig-y-Don.

4.527 Phil Dennett was asked why, mindful of Dr Kathie Bull's Report, Children's Services were still having problems dealing with children with behavioural difficulties. He replied that the small number of children remaining in residential care were "*probably the most challenging*" and also thought that it could be partly explained by the political decision to use a six-bedded home, when his preference would have been for three-bedded units.[671] He also stated that an outside person, Mike Weldrick, was brought in to analyse each and every report where physical restraint had to be used.[672]

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[666] Some requiring police attendance, some recording physical restraint, some recording violence and aggression

[667] Reports requesting police attendance, recording physical restraint, incidents of violence and aggression

[668] WD9029

[669] WD009022

[670] WS000708/6

[671] Day 134/118

[672] Day 134/118–119

4.528 By October 2014, Brig-y-Don was considered to be "*no longer in a state of crisis"* although there was still some way to go.[673] Improvements still needed included routines being put in place and unity of purpose among staff, refurbished rooms, improved all round relationships, and the project lead doing regular daytime hours as opposed to shifts. Staff at the Brig-y-Don Flat were praised for their care for the one young person in residence, although the accommodation was criticised as leaving him isolated.

Findings: Brig-y-Don: run by the States of Jersey (2011 to present)

4.529 On the basis of the documentary evidence, between 2012 and 2014, the management and organisation of the Home were not adequate. By then, this was an entirely different institution to that which had been privately run. Although the number and quality of staff appear to have been adequate, in 2013, the Board of Visitors were "*very concerned"* about the situation at the Home, noting that it had "*the character of a turbulent children's home".* Reports show a high number of incidents of violence and aggression, and several requests for police attendance and incidents of physical restraint. We acknowledge Phil Dennett's evidence that residents may have posed challenges and that a change in management occurred in 2014 after he also expressed "*great concerns"* about the Home. Things appear to have improved from this point.

4.530 The culture of the Home during this period appears to have been a negative one, with the Board of Visitors noting in 2012 that it did not have a "*happy relaxed atmosphere"* and in 2013 that "*the culture of the home needs to change in order to provide a suitable environment for the [young persons] to grow and develop".*

4.531 We do not have sufficient evidence to come to a finding on the governance of Brig-y-Don during this period, however we do note the intervention of Children's Services following the critical reports by the Board of Visitors and other outside organisations.

[673] Report WD009325/15

Family Group Homes

General background across the Family Group Homes

4.532 We have begun by setting out some of the general background across the Family Group Homes (FGHs) that existed in Jersey from 1960 to 1993, and making findings on these Homes as a whole. We then go on to look at each of the individual Homes and make findings on the adequacy of the management, organisation, culture and governance of the Home.

4.533 In 1960, the Education Committee sought approval from the Housing Committee for its proposal that a purpose-built FGH should be built. This replicated the approach adopted in England that FGHs should, where possible, be part of new housing stock to blend in with ordinary family housing. In June 1960, the Housing Committee let the first house selected, 46 Nicholson Park, to the Education Committee as a FGH. In 1962, the Housing Committee allocated a house on the Clos des Sables estate, for use as an FGH.

4.534 In 1970, the Home Office Inspectorate report[674] noted that the five FGHs seemed to have been envisaged as large foster homes, however some had developed differently. It recommended that that the FGHs needed a more professional development into small children's homes, and a possible later expansion in numbers. The Inspectors also said that they hoped to see the Houseparents regarded as "*salaried staff carrying out a defined job, rather than as substitute parents looking for the particular emotional satisfaction which this can offer*". They thought that the staffing structure of one Housemother with a part-time relief assistant and a domestic help was "*quite suitable"* but that the number of children needed to be limited to eight, including staff children.

4.535 In July 1976, a review of the FGH system was carried out by the Education Committee.[675] The review noted that:

[674] WD006194/4–5

[675] WD001402; WD001403

4.535.1 the Houseparents at the different FGHs approached the task differently, ranging from a strictly professional approach to a "*more cosy, but questionable atmosphere of some sort of pet name for the Housemother, e.g. 'mummy' or 'auntie'*";

4.535.2 members of the sub-committee were recommended to visit regularly, giving no more than two hours' notice;

4.535.3 CCOs tended not to visit the children very often because the FGHs were regarded as a reasonably stable environment;

4.535.4 the Housefather is responsible for the Home and for supervising staff in the event that the Housemother is absent for up to four weeks or more;

4.535.5 some Housemothers felt isolated from their colleagues in child care (both residential and field staff) and resented the inevitable change in field staff allocated to the children.

4.536 In 1977, a statement from the President of the Education Committee about FGHs noted, among other things, that the five original FGHs could together accommodate 33 children, but, following a re-organisation, they could provide places for 18–20 children. Senator Jeune said that they would continue to provide FGHs for as long as there are children in care requiring this kind of environment and if more young children came into care in the future, the Committee would wish to open more.

4.537 The maximum number of FGHs at any one time was five. During most of the 1980s, only two remained: Blanche Pierre and Clos des Sables. Following allegations of abuse, Clos des Sables closed in 1989 and Blanche Pierre in 1993, ending Jersey's use of FGHs.

4.538 The SCCO responsible for the FGHs was Brenda Chappell. She was unable (by reason of ill health) to give evidence to the Inquiry about her role as SCCO.

4.539 Anton Skinner gave the following general evidence to the Inquiry about FGHs:[676]

4.539.1 They were designed for children on long-term placements in care but for whom foster homes could not be found.

4.539.2 Housemothers undertook rudimentary training (such as on nutritional needs) but it was not extensive.

4.539.3 The aim of the FGH may have been a naive concept; asking two people without any training to look after large groups of emotionally damaged children. The work required a high level of understanding, patience and intuition and he felt that Houseparents were given an impossible task.

Findings: Family Group Homes as a whole

4.540 We find that the rationale for setting up FGHs in the late 1950s/early 1960s, based on Patricia Thornton's experience in England of breaking down large institutions and giving children in care the experience of living in a family, was an appropriate policy to have adopted at the time.

4.541 By the early 1970s, the concept of the FGH, as a means of residential child care in Jersey, was being abandoned across the UK as unworkable, not least because it was becoming difficult to recruit couples only one of whom would be paid. Poor oversight and unsuitable, inadequately trained, or poorly supervised staff, led to children suffering abuse or failing to receive nurturing care.

4.542 The expectations and responsibilities placed on the Houseparents (particularly the Housemother) were too onerous and absent of any professional training or guidance.

4.543 A system whereby the Housefather was expected to look after children in care, without being employed by or accountable to Children's Services, was inadequate.

[676] Days 87–89; WS000614

4.544 In 1970, the Home Office Inspectors advocated more professional development of FGHs, with the Housemother less emotionally involved.[677] This was not pursued in Jersey and arrangements for support were inadequate.

4.545 The intended arrangements for support were inadequate. Visits by CCOs were irregular and ad hoc visits by the Children's Officer insufficient. In an island as small as Jersey, this is inexcusable and inexplicable.

4.546 There was insufficient attention paid to the need to maintain children's links with members of their birth family. Indeed, on the evidence available to the Inquiry, in some of the FGHs, those links were positively discouraged.

Nicholson Park/Clos de Roncier

4.547 There is limited information about the operation of this FGH due to the length of time that has elapsed since its closure in 1977 and the fact that the only Houseparents, Mr and Mrs Edwards, are both deceased.

4.548 We note that Mr and Mrs Edwards were offered the Houseparents' posts at Nicholson Park, and the Children's Officer's 1961 report stated that the children were "*now much welded into a family".*[678] As with other FGHs, some oversight of the running of the Home appears to have been by way of biannual reports about the children presented by the Houseparents.[679]

4.549 In March 1965, the Houseparents and residents moved to a new property at Clos de Roncier, which coincided with an increase in the number of residents.[680] Following Mrs Edwards' death in 1977, the Home was closed. The residents were redistributed across the other States' facilities and Mr Edwards was given notice to quit.[681]

[677] WD006194/4–5
[678] WD004986
[679] E.g. WD004991 from Jan 1965
[680] WD004991
[681] WD004998

Findings: Nicholson Park/Clos de Roncier

4.550 We do not have sufficient evidence on which to make findings about this FGH, although we do note that there is only one allegation of abuse made in relation to this Home, and that the children were described in 1961 as "*welded into a family".*

Clos des Sables

Organisation and management

4.551 Janet Hughes told the Inquiry that,, on her appointment as Housemother at Clos des Sables in 1964, the expectation was that the maximum number of children residing at the home (including her own) would be 10.[682] Instead of applying, she was approached by Patricia Thornton and Charles Smith, who explained the concept of FGHs to her during an informal first meeting.[683] She said that the expectation was that Les Hughes *"would have some input for which he was not going to be paid a salary, but he was given free board and lodgings*".[684]

4.552 The Children's Officer received positive references for Janet and Les Hughes prior to their appointment. Janet Hughes was described as a *"truly wonderful mother*", Les Hughes as someone who would "*assert his discipline in a sensible and fatherly way*".[685]

4.553 WN283 applied for a job at Clos des Sables, having seen an advertisement in the newspaper. She had no qualifications but had one reference from her father's solicitor saying that she came from a good family. She recalled an informal conversation with Janet and Les Hughes and a short interview with Charles Smith. She met the children and was given a book of information about them.[686]

[682] Day 69/17
[683] Day 69/16
[684] Day 69/20
[685] WD006122/10
[686] WS000725/2

4.554 Janet Hughes initially had only one day off a week, when she was also expected to visit the Children's Department.[687] When WN283 joined, Janet Hughes was able to have two days off per week. WN283 states that she did everything from domestic work to helping with the children. She worked over 40 hours per week, mostly when Janet and Les Hughes were not there. There were periods when she worked three days on her own which she found "*extremely challenging*". According to WN283, it was impossible to get hold of a CCO at the weekend although Children's Services did occasionally send a member of relief staff to help.[688] She felt that Janet and Les Hughes "*did the bare minimum to keep the place ticking over*" and in her view the Home was "*very badly run".*[689] In a Probation Service Report from 1989, it is noted that Janet Hughes had described herself as having "*reached a stage of near breakdown"* and having found the task too difficult almost from the very beginning.[690]

4.555 Janet Hughes recalled that she was assisted at the outset by WN635 who worked 22 or 25 hours per week.[691] According to Janet Hughes, there was only a single staff member on duty at any one time and she relied on her husband to help especially during the evening meal. In a 1989 report Anton Skinner noted an increase in the staff in 1984 to three in order to give the Hughes at least two days per week out of Clos des Sables.[692] Janet Hughes commented that *"they should have had a higher level of staffing, not all that responsibility should have been dumped on one person. I mean okay, my husband was there, but it was not his responsibility ultimately".*[693]

4.556 In his police interview in 1989, Les Hughes said that he was employed outside of the Home, but helped his wife attend to the children's needs when he returned.[694] Janet Hughes recalled in evidence that Les Hughes was

[687] In a Probation Service Report from 1989, Mrs Hughes described that she found her task too difficult almost from the beginning

[688] WS000725/3

[689] WS000925/17

[690] Day 69/57

[691] Day 69/18

[692] WD000166

[693] Day 69/95

[694] WD006099

effectively involved in all parts of looking after the children, as well as assisting with maintenance and repairs. He spent time alone with the children, including reading them bedtime stories, which seemed "*quite normal"* to her.[695] Janet Hughes said that she would have been unable to manage Clos des Sables without his input and that Children's Services expected him to help with the children.[696] He also said that he attended Education Committee case conferences if he was available and was permitted to do so. He was, in the main, fully acquainted with the history of the children in his care.[697]

4.557 There were several short periods when Janet Hughes was ill and Les Hughes was temporarily employed as a CCO and paid a salary.[698] He rejected the request from Children's Services that he also be employed and Janet Hughes had the feeling that Children's Services knew about Les Hughes' increasing role, but thought it was *"an answer to their prayers, they did not have to find someone to fit this role".*[699] Janet Hughes recalled that her husband was *"totally trusted"* by the Children's Department,[700] but said that she was *"surprised when I read that he was not supervised, or asked questions or anything".*[701]

4.558 Janet Hughes told the Inquiry that she was never offered training nor expected to receive any before starting at Clos des Sables. The occasional symposium, organised for all the Family Group Homes, took place roughly every six months; these included some role-playing and discussion about behavioural problems.[702]

4.559 WN283 said "*I was expected to do everything to meet the different needs of all of the children, with no support or training*".[703] In her 15 years at Clos des Sables, WN283 received no training. Even after the allegations about Les Hughes came to light, she noted "*we did not receive any training in how to*

[695] Day 69/51
[696] Day 69/54
[697] WD006102/15
[698] WD006122/20
[699] Day 69/62
[700] Day 69/77
[701] Day 69/95
[702] Day 69/48
[703] WS000725/4

deal with disclosures of allegations of abuse. There was no change to the way that we worked".[704]

4.560 In response to a question about whether training may have made a difference to her husband's sexual assaults, Janet Hughes said:

> "*I'm sure it would have done. I for one would have recognised the signs when this child was getting very distressed. There were times when she was not a happy little girl and she was very distressed, but she had difficulties with her own mother … to me she was reacting quite normally to all the awful things that were happening to her …"*[705]

4.561 At one stage, Janet Hughes came to the view that the Home could not "*work in the way intended by the Children's Department",* recalling that there came a time when the residents were *"a very disparate group of all sorts of children with various problems, each one of them needing more attention than another".* She later described this as having gradually evolved from a Family Group Home into a *"small children's home".*[706] She recalled that as each child left, the gap was filled almost immediately by another child and that this high turnover caused difficulties in that the children were expected to welcome this new person into the situation.[707]

4.562 Janet Hughes retired in March 1990 following the conviction of Les Hughes. Anton Skinner did not instigate any investigation into the governance of the Home. Indeed, notwithstanding the fact that Janet Hughes had had the day-to-day management of the Home and the wellbeing of the children, he wrote a letter on behalf of the Education Committee passing on "*their appreciation for your many years of loyal and excellent service to the Department*".[708]

4.563 When Audrey Mills was asked to take over at Clos des Sables for a few months after the departure of Janet and Les Hughes, she was told that abuse had taken place but was given no details. She said "*the role I was given was*

[704] WS000725/17
[705] Day 69/94-95
[706] Day 69/66
[707] Day 69/83
[708] WD006104

to give stability to the children and I stayed at the Home until (the remaining children) were placed elsewhere".[709]

4.564 WN283 described the environment as "*immediately more relaxed*" when the Home was managed by Audrey Mills. Children went on day trips for the first time ever and Audrey Mills "*did much more for the children*".[710]

Culture

4.565 WN283 said that Janet and Les Hughes "*rarely showed any love towards the children*" and she recalled "*the negative environment of the home*". The food that Janet Hughes left for the children "*never seemed to be enough*". Janet Hughes locked the food cupboards and the fridge freezer which WN283 "*found very odd, and I had to go out to buy more food for the children*". She was not reimbursed but "*could not let the children starve*".[711]

4.566 Marnie Baudains (CCO at the time) thought that efforts had been made to integrate the children within the estate and that the Home had quite a pleasant feel. She thought it odd that the Hughes' adult son lived at Clos des Sables after Les and Janet Hughes moved out into their own accommodation. She also noticed the frugality of food at Clos des Sables but did not recall a padlock on part of the fridge.

4.567 Janet Hughes recalled that she certainly did not want the children at Clos des Sables to call her "Mummy" – some called her "Auntie", others called her "Janet" and one or two even referred to her as "Mrs Hughes", which she says was "*fine by me".* She also said that she and her husband made no distinction between the children in care and their own children, which was corroborated by her daughter.[712]

4.568 The 1981 Lambert and Wilkinson Report[713] noted:

[709] WS000585/11
[710] WS000725/8
[711] WS000725/7
[712] Day 69/88
[713] WD007382/63

4.568.1 the Houseparents had excellent relationships with local schools and the children were *"exceptionally well integrated into the local neighbourhood*";

4.568.2 Janet and Les Hughes maintained a good relationship with CCOs. Although there was frequent contact with the Children's Officer, "*one would have looked for more frequent contact with senior staff";*

4.568.3 most of the children had been resident in other establishments and presented few major problems but were vulnerable and in need of a *"sympathetic and secure home base*";

4.568.4 the FGH offered a reasonable alternative in cases where natural parents may have objected to fostering.

4.569 WN23 was a resident from the age of six until she was 15 (1974–1985) and described that in practice, Janet and Les Hughes ran Clos des Sables along with another full-time staff member. The Hughes' son also lived in the Home which WN23 thought was odd – a sentiment shared by WN148.[714] WN148 told the Inquiry that Janet Hughes was in charge and that Les Hughes acted as "*backup*".[715]

4.570 WN148 moved to Clos des Sables in 1978 and said that Janet Hughes showed no love or emotion and was "*there to do a job*".[716] When social workers visited it was to speak privately with Janet Hughes. They only spoke briefly to WN148 and then in a room adjoining the kitchen. WN148 therefore felt unable to tell social workers what was going on at the Home. She confirmed that Clos des Sables was run on a tight budget and that the children could not just help themselves to food.[717] WN148 told the Inquiry that it was Les Hughes who put the children to bed.[718] Once she had left Clos des

[714] WS000083/6
[715] Day 21/29
[716] Day 21/30
[717] Day 21/28
[718] Day 21/37

Sables she was not allowed to return to visit WN23 because she was not a family member.[719]

Governance

4.571 Janet Hughes said in evidence that it was her impression that Charles Smith (Deputy Children's Officer and then Children's Officer) was more interested in financial expenditure at Clos des Sables rather than the wellbeing of the children.[720] Each child had a CCO who visited with varying degrees of regularity. Some would turn up unexpectedly and she "*did her level best*" to give them the opportunity to speak to the child individually in a room alone or by taking the child out.[721]

4.572 WN283 did not remember the children "*ever being given the opportunity to talk to a social worker on their own".*[722] She never received guidance from Children's Services or any information about the children's backgrounds. There was no supervision or monitoring and it was her impression that Brenda Chappell (Senior Child Care Officer) did not want to hear about what she had to say in case it "*rocked the boat".* Contact with Children's Services was not encouraged.

4.573 David Castledine (CCO) disagreed with the suggestion that Family Group Homes were isolated. He said that he visited fortnightly or at least monthly; this was the same with foster placements. He could not comment regarding his colleagues at the time; they each had responsibility for their own caseload.[723] He did not think that Les Hughes had managed to assault children at Clos de Sables through lack of supervision.

4.574 Janet Hughes produced reports for the Children's Sub-Committee, which she read out at meetings and on which she answered questions if necessary. Some members visited Clos des , and Janet Hughes recalled that they "*would*

[719] Day 21/51
[720] Day 69/36
[721] Day 69/38
[722] WS000725/10
[723] Day 85/19

always listen to any problems that I had".[724] Despite this positive relationship, Janet Hughes recalled that, in response to the changing environment at Clos des Sables, she was "*left with the problem and was supposed to work it out for myself".*[725]

Findings: Clos des Sables

4.575 The management and organisation of Clos des Sables was inadequate. The lack of support staff for Janet Hughes meant that she barely had any time off and was often caring for 10 children by herself. Although this improved by 1984, all that the Hughes' could do was "*the bare minimum to keep the place ticking over" and* Janet Hughes described herself as having "*reached a stage of near breakdown",* having found the task too difficult almost from the very beginning. This was, at least in part, caused by the structural problem of FGHs themselves, which had the number of residents of a small children's home, and the staffing structure of a foster home.

4.576 Another of the structural problems with FGHs was highlighted at Clos des Sables: there was a reliance on Les Hughes to provide care for vulnerable children in the care of the States of Jersey, without any training, supervision, or questions asked. He was effectively carrying out the role of foster parent to a large number of children, without any of the same supervision. In this case, the nature of his role had dreadful consequences for children living in the Home.

4.577 Janet and Les Hughes were recruited in the 1960s with positive references, which we consider was an adequate recruitment process by the standards of the time.

4.578 There was a lack of training for FGH Houseparents and staff, which was inadequate by the standards of the time. This lack of training continued up to 1989 (even after the disclosures of abuse had been made).

[724] Day 69/81
[725] Day 69/102

4.579 Evidence on the culture of the Home is mixed, with witnesses noting the frugality of food available to the children and some noting locks on cupboards and the fridge. On the other hand, Marnie Baudains thought that the Home had quite a pleasant feel and Lambert and Wilkinson noted that the children were well integrated into the local community. The fact that for most of the Home's existence, children were being sexually abused in a relatively small environment, suggests to us that there was a culture of impunity.

4.580 Governance of the Home was inadequate. Although CCOs visited fairly regularly, senior social workers within Children's Services (for example, Brenda Chappell and Charles Smith) largely left the Hughes' to run the Home by themselves. It is unclear how regularly CCOs were able to see children by themselves, but we note that it was their efforts that contributed to disclosures of abuse in the late 1980s.

Family Group Home run by WN279 and WN281

Organisation and management

4.581 The job of Housemother was offered to WN279 in November 1966.[726] She had previously worked for a couple of days per week at another of the Family Group Homes and was interviewed along with her husband at the Children's Office with Patricia Thornton and a couple of others, during which they provided some background information about their beliefs and way of life. They were never asked about qualifications or previous experience, although WN281 thinks that WN279's previous experience in dealing with people who were sick and vulnerable was looked upon favourably. He does not remember providing any references, but is sure that references would have been obtained.[727]

4.582 WN279 was paid a salary plus a "*responsibility allowance*" and a further sum in recognition of the fact that she had certain qualifications. Her husband WN281 was entitled to free board and lodging in return for helping with the

[726] WS000713/3
[727] WS000713/3

children and household activities. WN279 accepted the post from 1 January 1967 and until the FGH was ready, she worked at HDLG.

4.583 A report from December 1967 notes that two Assistant Housemothers worked at the Home.[728] The post of full-time relief Housemother was created in April 1969. One of the original Assistant Housemothers resigned in October 1970 and was replaced by a part-time domestic member of staff.[729] WN287 moved to the FGH in 1975, after having trained in England and qualified as a Residential CCO there, and having been involved in child care work in Jersey for several years. When she was appointed, Brenda Chappell asked her to report any concerns in respect of children in the care of WN279, which she believes was simply because Brenda Chappell was anxious to ensure that the children were OK.[730] WN281 notes that relief staff would help out with the chores and generally with the children. Prospective applicants would apply to Children's Services for the job, but he and WN279 would be involved in interviewing them and WN279 would make the final decision as to the choice of the candidate.[731]

4.584 WN279 and WN281 had every other weekend off and the relief staff would care for the children including their own children. WN281 worked outside of the Home during the week. He left the practicalities of running the Home to WN279. They did not receive any training while at the FGH, nor any guidance as to acceptable forms of discipline.[732]

4.585 In May 1974, WN279 fell seriously ill, requiring surgery. The Assistant Housemother took charge until WN279's return to full-time duty in September 1974.[733] WN281 said that during the next 18 months caring for the children was extremely difficult and they relied more on the support of the Assistant Housemother and relief staff who effectively became the primary carers.

[728] WD001390
[729] WD001407
[730] WS000594
[731] WS000713/5
[732] WS000713
[733] WD001387

WN281 told the Inquiry they considered giving up the Family Group Home at this stage but did not want to let down the children.[734]

4.586 In January 1977, the Children's Sub-Committee was informed that WN279 wished to retire on the basis that she had been advised by her doctor to cease working. She was granted early retirement on the grounds of ill health and a temporary Housemother was appointed on a monthly basis.[735] WN281 says that they took this decision themselves despite his concerns about what would happen to the children,[736] although (as we discuss in Chapter 9) there is also some evidence to suggest that WN279 was asked to retire due to an allegation being made against her.

4.587 The Assistant Housemother, WN287,[737] remained at the FGH until two of the remaining children were placed back with their mother and the other three at La Preference. She said she did not receive any additional training before taking on the role[738] and left at the end of August 1977.

4.588 By the time the Home closed in August 1977, only a small number of children remained, some of whom were "*rehabilitated*" with their mother. An Educational Psychologist recommended that the remaining children be placed in a larger establishment "*because of their experiences towards the latter part of [WN279]'s service*". There is no further information as to the "*experiences*" referred to by the psychologist but we note the allegations of physical assault that had been raised against WN279 at that time, as discussed in Chapter 9.

Culture

4.589 In evidence to the Inquiry, WN281 made a number of points about the routine, the approach to discipline and the contact between the children and their natural families, including:[739]

[734] Day 137/22
[735] WD001399
[736] WS000713/17
[737] WN287 was a qualified residential Child Care Officer who moved to the Family Group Home in 1975
[738] WS000594
[739] WS000713/10; Day 137

4.589.1 They occasionally took the foster children (those children who were placed in their care by the States of Jersey, as opposed to being their own children) away on holiday with them but not always.

4.589.2 The reason their own children went to private school and the foster children went to state schools was that they wanted their own children to go to Catholic school.

4.589.3 They did not treat the foster children and their own children differently, and there was no segregation.[740]

4.589.4 If children misbehaved, he would speak to them and persuade them what they had done was not right. If that failed, he would pretend to be really cross. He may have given the children a tap on the bottom over their clothing, but certainly did not hurt them. He did not believe in violence.

4.589.5 WN279 may have raised her voice at the children from time to time and given them a light tap on the wrist, but she did not injure them.

4.589.6 The foster children had almost no contact with their natural families but knew that WN279 and WN281 were not their natural parents.

4.590 WN281 was asked to comment upon a contemporaneous note from the children's CCO, Ms Hogan, in which she stated that WN279 had told two of the children that they were to address a letter to their mother by her first name rather than "*Dear Mummy*".[741] He said that his wife never stopped the children from writing to their mothers and that although the foster children called them "Mum and Dad" they never insisted upon it.[742]

4.591 In February 1975, allegations of physical assault were made against WN279, as discussed in Chapter 9. The CCO, Ms Hogan, noted some other matters at that time:

[740] Day 137/11
[741] WD009278/6
[742] WS000713/11

4.591.1 Mr Shepherd (Head Teacher for some of the children) commented that WN279 never came to parents' evenings or discussed the children's progress.

4.591.2 Mr Shepherd was unimpressed with WN279. None of the children were allowed to join any outside organisations.

4.591.3 WN279 was *"tense and watchful*" during Ms Hogan's visits to the Home and rarely left her alone with the children.[743]

4.591.4 The teacher for one of the residents (WN214) had mentioned that after one or two of WN214's friends went to tea at the Home, they had commented on the tense atmosphere.[744] Ms Hogan herself thought that there was a *"very controlled atmosphere*" in the Home and WN279 did not seem to want Ms Hogan to be alone to talk to WN287 (Assistant Housemother).[745]

4.592 In his evidence to the Inquiry, WN281 said in reply that he and his wife usually attended parents' evening; the children did join organisations such as Guides and Scouts; and although the Home atmosphere might have changed a little after his wife's illness, it was still "*a family atmosphere*". WN281 said that either Ms Hogan misinterpreted the situation or the record is not accurate.[746] As to whether there was any change in culture after his wife became ill he thought that the children would have noticed a difference. WN279 became much quieter and might have become a bit more impatient.[747]

4.593 The Assistant Housemother, WN287, told the Inquiry that the children were verbally chastised in her presence; some stood to attention and said "*Yes, Mummy*" and "*No, Mummy*". The children were called by their surnames when chastised and denigrated about their backgrounds.[748] WN279 spoke harshly to the foster children and did not look after their emotional needs, according to

[743] WD009278/25
[744] WD009278/23
[745] WD009278/25
[746] Day 137/335
[747] Day 137/23
[748] Day 76/149

WN287. On the other hand, children were (contrary to some suggestions) allowed to chat at mealtimes, and the foster children were not treated any differently to WN279 and WN281's own children. WN281 denied the negative assertions made by WN287 and said that his wife was a caring person.[749]

4.594 In a note from 1975, Ms Hogan recorded WN279 saying in respect of one group of the children that "*they are all, and always have been, persistent liars".*[750] WN281 said that they did not think of the children as "*persistent liars*".[751]

4.595 The witness evidence regarding life at this Family Group Home is diametrically opposed. Three former residents allege an abusive regime while other former residents maintain that it was a reasonably normal household.[752] In addition some witnesses state that the natural children were treated differently from the foster children, while others maintain that all were treated equally.

4.596 Examples of the evidence about daily life are set out below:

4.596.1 *"We lived under a reign of terror … Constantly beaten with sticks, belts, brushes, broom handles, whatever was to hand";*[753]

4.596.2 *"The beatings happened so often that it was just accepted by us as everyday behaviour and how we had to live";*[754]

4.596.3 *"All of these punishments I have described happened to all of the foster kids to some degree. They would not punish you in private but in front of the other kids";*[755]

4.596.4 *"The overall feeling I had is that it was a happy place. Every child there was treated exactly the same and like any normal child";*[756]

[749] Day 137/38
[750] WD005553/114
[751] Day 137/554
[752] The allegations and the response to the reporting of abuse are addressed under Terms of Reference 8, 10 and 11
[753] WN45: WS000168
[754] WN318: WS000170
[755] WN319: WS000171
[756] WN321: WS000174

4.596.5 *"During the nine years or so that I spent at* [the Family Group Home] *I always felt secure and never witnessed any mistreatment of any of the children";*[757]

4.596.6 *"It was a very happy home, just normal … I was not aware that there was a difference between the children, it did not register at the time that we had different surnames*".[758]

Governance

4.597 Children's Services staff visited about once a week, in order to meet with WN279 and check that everything was OK, and WN279 visited the Children's Office each month to present reports and discuss the progress of the children. WN281 said that people were always visiting and they had an open house policy.[759]

4.598 WN281 said that his wife was well supported by the Children's Office and would have told him if she felt otherwise. In his view, the biggest challenge to the system of FGH was the departure of Patricia Thornton, as her replacement Charles Smith did not have the same commitment to support him and his wife.[760]

4.599 WN287 thought that the infrequency of visits was one of the major downfalls of the FGH system. She thought that CCOs did not visit regularly enough and rarely spoke to the children, and reported her concerns about the lack of communication to Brenda Chappell. She thought it was important that the children had the opportunity to speak to someone independent and would speak to visiting CCOs about the children, although WN279 did not like the CCOs speaking to her or the children when they visited. WN287 could not recall any informal or unannounced visits by members of the Children's Sub-Committee.

[757] WN320: WS000172
[758] WN322: WD008825/40
[759] WS000713/12
[760] WS000713/114

Findings: Family Group Home run by WN279 and WN281

4.600 Management and organisation of the Home appear to have been largely adequate during this period, although there is a lack of primary evidence on the matter. The Home was sufficiently staffed, with relief and Assistant Housemothers taking on some of the workload.

4.601 In line with the other FGHs, neither the staff nor the Houseparents received any training, nor any guidance as to acceptable forms of discipline. Even for the standards of the time, this was inadequate, although it perhaps reflected the *laissez-faire* attitude taken by Children's Services to the management of FGHs. At the very least, Houseparents should have been made aware of the disciplinary rules in force at HDLG at the time.

4.602 Recruitment was adequate, with WN279 and WN287 both having some relevant qualifications and experience, and both going through interviews.

4.603 The evidence on the culture of the Home was mixed. For at least some of the residents, there was a tense and controlling atmosphere, in which the children in care were spoken to harshly and did not have their emotional needs looked after. WN279 said at the time that a group of the children were "persistent liars" and this sort of disdain appears to have been reflected in the culture of the Home. One witness referred to it as a *"reign of terror"* and the contemporaneous records suggest that the ability of the children to speak out was limited. On the other hand, other children spoke positively about their time at the Home.

4.604 As with other FGHs, we consider that governance was largely inadequate. Although there were regular visits by CCOs and reasonable support given to the Houseparents, nothing appears to have been done about Ms Hogan's critical reports in 1975 about the culture of the Home. Furthermore, as discussed in more detail in Chapter 9, the allegations of physical abuse that were raised in 1975 and 1977 against WN279 were inadequately handled at a high level: this was a failure of governance.

Norcott Villa

Organisation/Management/Culture/Governance

4.605 Following the dismissal of WN791 (discussed in Chapter 3 above), in April 1972, WN332 and WN331 became Houseparents of Norcott Villa. WN332's previous experience was in nursing and they got the job after having filled out an application form, along with a form entitled "Particulars of husband of applicant", and references.[761]

4.606 A report from the Houseparents, dated April 1974,[762] noted:

4.606.1 Problems with the property that made it difficult to create a real home atmosphere.

4.606.2 Difficulties meeting the rising cost of living which would affect the children's welfare if allowances were not reviewed.

4.606.3 Two children (WN171 and WN147) were resident at Norcott Villa for a year but were removed due to being "*totally incompatible"* with the other children in the group.

4.606.4 The view of the Houseparents that "*the children needed attention, more comfort and good food; that they needed discipline without harshness … and to meet more people not connected with childcare … and needed more fun and laughter in their lives*".

4.607 A report six months later provided further insight into how WN332 and WN331 saw their roles:

> "*Our aim is most definitely to provide a family atmosphere in which the children may develop physically, mentally and emotionally despite the damaging effects of former deprivation, for many of them come from seriously disrupted or disturbed families.*".

4.608 The Assistant Housemother WN287[763] recalled the differences between her experience at Norcott Villa and FGHs in England. In Jersey, children under

[761] WD005059
[762] WD005053

five were placed in FGHs if their siblings were there, whereas in England they were placed in foster care. Jersey did not have "live-in" residential Housemothers to assist the Houseparents. In comparison with her time in England she was required to do a lot of domestic work in Jersey. That inevitably reduced the time available for her to get to know the children.

4.609 In an interview with the police in June 2009, WN331 recalled that he would leave the Home each morning to go to work and return in the evening. During the day, WN332 and all of the staff cared for and looked after the children. WN331 said that he had no part in disciplining the children and that this was down to the other employees.[764]

4.610 WN171, a resident, mentioned the strictness of the regime under WN331 and WN332.[765] WN506 said that he did not like the fact that he had to share WN332 with so many other children.[766] WN745 said he found it difficult moving to Norcott Villa but enjoyed his time there, saying that playing football with all the children was great.[767]

4.611 The Houseparents separated in December 1979. WN332 remained at Norcott Villa until April 1980, when the Home closed.

Findings: Norcott Villa

4.612 In the first few years of the Home's existence (1969-1972), the management and organisation of the Home were inadequate. As noted in Chapter 3, WN791's employment was terminated following "*adverse reports affecting the care and control of the children and adolescents".*

4.613 The management and organisation of the Home under WN332 and WN331 appear to have been more adequate. Their reports from 1974 demonstrate good insight into the needs of the children in their care.

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[763] WS000594/7
[764] WD005555
[765] WD005064
[766] WD005554
[767] WD005556

4.614 Although there is not much evidence about the culture of the Home, it appears to have been relatively strict, but one in which the Houseparents recognised the need for children in care to have "*more fun and laughter in their lives*" – which we consider was a positive approach.

4.615 We do not have sufficient evidence to consider the governance of the Home during most of the time it was open, but we note that the Children's Sub-Committee was able and willing to intervene to dismiss WN791 in 1972 following adverse reports. This suggests that the Sub-Committee was able to take decisive action at this time, in contrast to the handling of allegations at other FGHs.

Blanche Pierre

4.616 As a result of the overlap between the matters we have to consider under Term of Reference 2 for Blanche Pierre, all are reviewed in one section, in a broadly chronological order.

Organisation/Management/Culture/Governance

4.617 In early 1980, Jane Maguire took over as Housemother in charge at Blanche Pierre. She had previously worked as a residential carer at HDLG and was NNEB trained.

4.618 Blanche Pierre was visited during the preparation of the 1981 Lambert and Wilkinson Report. The report detailed the layout of the property noting that the Houseparents have the use of one large sitting room and a moderate sized bedroom which *"allow for no privacy*". There was no office at the Home and the filing cabinet (containing the children's files) was located in the hall. The Inspectors noted the age range of the children to be from 12 months to 15 years; with a number of sibling groups, as well as individual children from separate families. There are references to some of the children having outside activities such as Cubs and Brownies and the Home having close links with the children's schools. The children were said to be, in many ways, "*experiencing as normal a family life as possible".*

4.619 The Report noted that Alan Maguire "*follows his own employment but takes an active part in the life of the Home in return for free board and lodging*". Another staff member was employed for 44 hours per week and there were nine hours a week of domestic help. Following the placement of a baby "*a second Housemother … who normally splits her time between the two Family Group Homes, is working forty hours per week".*

4.620 The use of a "daily occurrence" book was noted,[768] as well as a menu book, accounts and maintenance books. The Houseparents were said to have "*considerable autonomy*" in how they managed their budget, receiving a quarterly allowance for the Home. The Report also noted that case records on each child "*are extremely limited*" and review forms completely without input from the Houseparents. "*These are matters which require some attention*".

4.621 The Report concluded that Jane and Alan Maguire "*should be receiving help and support in understanding the needs and sensitivities of the children who have separated from their families".*[769]

4.622 Brenda Chappell, in her role as Senior CCO, had overall responsibility for the Family Group Homes at this time. In evidence to the Inquiry, Anton Skinner said that he would have expected Brenda Chappell to have provided Jane and Alan Maguire with the support identified by the Inspectors.[770]

4.623 Social Services records relating to children placed with Jane and Alan Maguire provide an insight into Blanche Pierre:

4.623.1 May 1981: Brenda Chappell reported to Charles Smith regarding a sibling group: "*the rota has been reorganised … and I have talked to Mrs Maguire at some length about her own personal problems*".[771] (There is no indication in the records as to the nature of Jane Maguire's "*personal problems*").

[768] This "daily occurrence" book may have developed into the "house diaries" referred to in evidence to the Inquiry
[769] WD007382/62
[770] Day 87/141
[771] WD000556

4.623.2 May 1981: another memo from Brenda Chappell refers to tension in the home, due to Jane Maguire's relative inexperience in dealing with parents. She is also described as being "*far too emotionally involved with the baby [WN81] … I am sure she has the potential to make an excellent Housemother but there are still problems that we must discuss and I will be seeing Mrs Maguire again".*[772]

4.623.3 June 1982: a CCO (Ms Bird) recorded contact with the father of some of the children who … "*said the children had told him that 'big Alan' smacked them a lot. He agreed the children do tend to exaggerate".*[773]

4.623.4 July 1986: Richard Davenport (CCO) recorded that a group of siblings recently admitted "*continue to settle well at Le Squez*".[774]

4.623.5 1987: Richard Davenport recorded that "*The 'ship' at group home now seems much more stable and by and large we seem to have a happy home*".[775]

4.623.6 1987: Jane Maguire completed a job questionnaire.[776] Under "*the purpose of your job*" was typed *"… to provide a secure, loving and happy family life for up to eight children … This role is a vital part of a necessary child care service to Jersey*". Under "*main responsibilities*" was included: "*The end product is to produce stable, confident, responsible members of society who will be the caring parents of the next generation of children in the Island*". Under the concluding part – "Additional Information" – the following was typed: *"I do this job with the help of my husband, as a couple we feel we can offer the children a stable, loving alternative family life. As this is a stressful job we both need the understanding and support of each other. We offer the children love without taking away the natural feelings towards their own parents. We feel that with the right care*

[772] WD000535
[773] WD000325
[774] WD000415
[775] WD000398
[776] WD006633/6

and preparation growing up is not always the frightening experience that [it] seemed [sic]. A great deal of my time is spent counselling children whose problems are not related to the home, but more to problems they bring after visits to relatives. Although I do not discourage these visits I often feel these are the reason for many of the child's problems".

4.623.7 December 1987: Richard Davenport visited and recorded Jane Maguire's request that Darren Picot be removed: "*I asked Mrs Maguire as to whether I should now embark upon the proposed specialising*[777] *as we had discussed at review but Mrs Maguire felt that this was not now likely to be productive. I thought we had agreed this course of action but cannot really embark without the Maguires' co-operation. There is a definite resistance by these Houseparents to 'outside intervention' and yet the frequency of being asked 'to do something' is quite frightening.*[778] *Mrs Maguire does seem to be incapable of handling Darren. Other staff have not made any such similar complaint about Darren to myself".*[779]

4.623.8 June 1988: Richard Davenport visited "*at Mrs Maguire's URGENT request*", noting: *"[Darren] once again. I was taken upstairs to Darren's bedroom and shown the further holes he had made in his bedroom door. I had a long session with the Maguires and also Darren. Darren maintains he wishes to remain at Family Group Home. He does agree he gets angry and feels this mostly with himself … he is a thirsty boy but says he is going to try not to drink at night in the hope of remaining dry … I see no real changes in the whole Group Home scenario. It seems to me that increasingly the church takes all priority. Mr and Mrs Maguire seemed tired and dishevelled on my visit … Darren still seems to be scapegoated and seems too sad too often … communication between the staff at the Group Homes seems poor. In any event I seem effectively*

[777] From other records, it would appear that this refers to behaviour therapy to be carried out by Pat Stevens
[778] WD000563
[779] WD000564

powerless to change the situation and wonder whether we should act on Darren's behalf".[780]

4.623.9 1989: Darren Picot was moved from Blanche Pierre to Heathfield and Richard Davenport prepared a report setting out his history with Jane and Alan Maguire.[781] It noted "*Ms Stevens'* (CCO in 1987) *assessment indicated that staff views often did not correspond to Mrs Maguire's own perception. Darren was kept in nappies by the Maguires, much to my own personal horror! Ms Stevens then left the Department, Mrs Maguire, after asking for help, had rejected Ms Stevens' conclusion. The status quo resumed with periodic complaints from the Maguires and requests to remove the boy".*

4.623.10 April 1989: on an unannounced visit Richard Davenport recorded*: "on entering Family Group Home Mr Maguire was at home and he became very agitated with his wife saying that he was 'sick of being talked to by the children … like dirt'… Quite frankly he was ranting and Mrs Maguire was clearly upset. I felt it best to leave".*[782]

4.623.11 June 1989: Anne Herrod (Senior CCO) wrote to Richard Davenport regarding WN85… "*she has never been happy at Le Squez. Jane and Alan are always rowing, they sent Darren away … They are not able to watch TV until after tea … [certain children get anything they asked for]. The others can do no right. Jane is always picking on her and calling her names*".[783]

4.623.12 July 1989: Richard Davenport compiled a report on WN85's difficulties at the Home noting at one point: "*Alan Maguire seemed very much in two minds as to his desire to have WN85 return and is not prepared for any flexibility in "House Rules". Such rigidity is unlikely to succeed in WN85's case".*

[780] WD001115
[781] WD000201
[782] WD000548
[783] WD000519

4.623.13 January 1990: Mr Dallain (CCO) recorded a visit to Children's Services by WN83: *"[he] said that he had fallen out with the Maguires and wished to go to the Boys Hostel. He assured me that this was not just an isolated incident but he had been unhappy there for some time and on several occasions Mr Maguire had apparently told him that the door was there if he wished to leave … The Duty Officer was not informed that WN83 was missing".*[784]

4.623.14 February 1990: A memo from Geoff Spencer to Richard Davenport in the same month recorded Jane Maguire's willingness to help one of the children with parental loss and said "*It may be useful if we arranged to meet in order to discuss the children at Le Squez in general … I know that you have very definite views on this and would wish to take account of them when planning with Jane and Alan in our supervision sessions*".[785]

4.624 We note that the records in this decade show regular six-monthly reviews of children placed at Blanche Pierre by CCOs.[786]

4.625 During this decade (1980–1990), Marion Robson was moved from HDLG to work as Relief Care Worker at two group homes (Blanche Pierre and Clos des Sables); she spent more time at the former. She told the Inquiry that Jane Maguire was *"very much in charge … it was very much run to her requirement and liking".* She never saw Jane Maguire hit the children but she was strict and "*she could reprimand the children if she did not like them saying certain things, or a certain way they did something*".[787] She remembers trying to have a rapport with the children as she had had at Haut de la Garenne and Jane Maguire taking her to one side and telling her that she was the "*Mum*", recalling: *"there was a kind of jealousy really she did not want anybody else to have a close relationship with the children … she was not a lady who took any sort of criticism".*

[784] WD000338
[785] WD000409
[786] See, e.g., WD000373, WD000384, WD000400, WD000412, WD001160, WD001161, WD001099, WD001116
[787] Day 76/77

4.626 Marion Robson said that Jane Maguire preferred certain children to others: "*Darren Picot … would end up coming in from school and being told to get his pyjamas and dressing gown on and basically not do very much … I felt very sorry for him".*[788] She did not remember him being made to stand in a corner and did not remember Jane Maguire washing the children's mouths out with soap, but with regard to the latter, said: "*she was very much the sort of person who would have still done that type of thing*".

4.627 She recalled Jane Maguire criticising the children's parents in front of them.[789] None of the children complained to Ms Robson – in her view "*I just do not think they had the confidence to talk about what was happening".* Marion Robson thought that "*looking back*", she should have intervened and told Jane Maguire that her treatment of the children was "*unacceptable*". She remembered visits to Blanche Pierre from Brenda Chappell and described her relationship with Jane Maguire as "… *a kind of cosy relationship … it lacked professional scrutiny*". Brenda Chappell did not ask her about the children and had she complained about the treatment she said "*I do not know if I would have been believed*". She also said: *"I mean really I suppose I could have said something to Jane. I think she knew by our expressions we … were not too happy about the situation but it was very much her husband's wishes and I think she was torn between the feeling that it was inappropriate but at the same time not wishing to fly in the face of her husband's say so … she would say to the children 'You cannot disobey Big Al'".*

4.628 WN307 also worked at Blanche Pierre between 1980 and 1989. She told the police in 1998: "*I always remembered the time I spent at the Home as happy … I worked at the Home every single day … there was never any sign that anything was wrong … the Maguires were always very fair [with the children] … I never saw any violence used".*[790] When Marion Robson was asked to comment on this statement, she said: "*It's strange because I thought she, like me, thought there were some problem … .it was only concerning the one little boy that … she was not very happy about*".

[788] Day 76/78
[789] Day 70/80
[790] WS000549

4.629 In her statement to the Inquiry, Susan Doyle (staff member) described the terror of the children when they returned home from school, Jane and Alan Maguire's strictness and the constant shouting at the children.[791]

Residents' perspective

4.630 In summary, a number of the former residents describe a harsh regime with silent mealtimes and frequent punishments; only allowed to speak when spoken to and punished by hitting with a spoon in the event of any breach. Corroborated by the "Home Diary",[792] the daily routine was punctuated with punishments; smacking; making children stand on "sentry duty", depriving them of food and privileges, washing mouths out with soap for swearing and hitting them with a slipper and a sandal. The washing of mouths with soap for swearing was said to be one of the House Rules as was the re-serving of food at subsequent meals if a child did not eat it.[793] WN82 said that "*the soap happened a couple of times a week*" and the *"hitting happened nearly every day and went on for the six years I was there".*[794]

4.631 WN76 said that "sentry duty" was a regular occurrence. A child was made to stand by the front door, "*even in winter we would be in our nighties*" and "*forced to stay there until we nearly collapsed*".[795] Darren Picot told the Inquiry that he was made to stand with his nose to a tree (called, by the residents, "Darren's tree") for at least two to three hours, wetting himself if he could not hold his bladder.[796]

4.632 A common theme in the evidence of former residents is that Jane Maguire would threaten the children with punishments to be meted out by her husband on his return home from work. "*She did not have to do it so much because she'd say 'wait till Alan gets home' and we'd be petrified*".[797]

[791] WS000547
[792] WD000205 – Home Diary corroborates this account
[793] WS000547
[794] WS000160
[795] WS000160
[796] Day 25/111
[797] WN83: WD000313

4.633 With regard to bedwetting, WN76 and WN82 were made to wear nappies until they were at least 11 or 12 years old, according to former residents and staff. In the case of WN76 it is alleged that she had to strip her bed each day, was not allowed to drink after 5.30pm and was made to eat dry crackers. Susan Doyle also confirmed that WN76 received no bereavement counselling when one of her parents died and no medical assistance to deal with her enuresis: "*I have seen WN76's mouth dry and encrusted, it was so dried out."*[798]

4.634 WN76 told the Inquiry that Jane and Alan Maguire ate fish each Friday. Notwithstanding the fact that she hated fish, she described being force fed by Alan Maguire. She went for periods without food and had to steal dog biscuits from the cupboard.[799]

4.635 Three former residents give a more positive account of their time at Blanche Pierre:

4.635.1 WN248 (1980–1985) "*the home was run as a normal house – rules which people had to abide by, as you would have in any home – none of the kids ever complained to me about their treatment*".[800]

4.635.2 WN247 (1979–1984) *"I never saw anyone mistreated – they were punished but never mistreated – they were grounded or had their pocket money stopped but they were never hit".*[801]

4.635.3 WN316 (1976–1987) describes the arrival of Jane and Alan Maguire as marking an improvement in the running of the Home.[802]

4.636 Jane and Alan Maguire left Blanche Pierre in 1990 and, from June 1990, Audrey Mills managed the Home. The Home was the last FGH in Jersey and closed in 1993.

4.637 Audrey Mills was unaware of the specific reasons for Jane and Alan Maguire's departure and why she had been brought in to manage the Home. In her

[798] WS000144
[799] WS000166/3
[800] WD000217
[801] WD000576
[802] WD000577

statement[803] to the Inquiry she said there was no formal handover: *"I took the children out to give the Maguires time to remove their things from the house*".[804] She recalled that all the children lacked confidence: *"they would tell me how the Maguires used to call them stupid and generally belittle them … the thing that struck me most … was their use of the phrase "we cannot do this" or "we're not allowed".*

4.638 When Blanche Pierre closed in 1993 Audrey Mills fostered several of the children in a house across the road from Blanche Pierre. She received "*very little help if any from Children's Services*".[805]

4.639 The Inquiry made attempts to locate Jane Maguire with a view to inviting her to give evidence, but those attempts were unsuccessful.

Findings: Blanche Pierre

4.640 The management and organisation of the Home were inadequate, particularly in the last few years of the 1980s. Jane Maguire tried to prevent staff from establishing a rapport with the children and certain children were scapegoated. The inadequacies of Jane and Alan Maguire were blamed on the children, at least one of whom was sent away.

4.641 Their approach to the issue of bedwetting was inexcusable – Jane and Alan Maguire subjected the children to humiliating and degrading treatment by the standards of the time.

4.642 Recruitment to the Home, on the basis of the evidence that we have, was adequate. Staffing numbers appear to have been sufficient and staff were suitably qualified for the standards of the time.

4.643 The culture of the Home, on the balance of the evidence, was extremely negative, at least in the second half of the 1980s. Purely on the basis of contemporaneous records and the evidence of members of staff, we find that Jane and Alan Maguire oversaw a punitive and strict regime in which certain

[803] WD008858
[804] WS000585
[805] WS000585

children were terrorised. As reported by the former residents and corroborated by the Home Diary, the daily routine was punctuated with harsh punishments that were completely inappropriate, including hitting, washing of mouths, and making children stand in one place for prolonged periods.

4.644 We note the reports of at least one member of staff and some children that suggest a more positive culture, and observe Jane Maguire's 1987 comment that they "*offer the children love"* and that her job was " *… to provide a secure, loving and happy family life"* for the children. However, we think that, on balance, this did not represent the reality of life at the Home, at least in the late 1980s.

4.645 Governance of the Home was inadequate. Although the response of Children's Services and the Education Committee to the allegations of abuse is discussed in Chapter 9, even before such allegations were made, there should have been intervention. As far back as 1987–1988, CCOs were recording Jane Maguire's inability to cope and resistance to outside intervention, yet nothing was done about this.

4.646 Brenda Chappell's friendship with Jane Maguire meant that she became unable to apply proper professional scrutiny in her oversight role as Senior CCO. Individual CCOs appear to have carried out regular reviews and wrote reports, some of which contained damning information, yet their concerns were not heeded at a higher level. This suggests that there was inadequate supervision of CCO records.

4.647 Lambert and Wilkinson had noted, as early as 1981, that there was a daily occurrence book, which likely became known as the 'Home Diary'. There is no evidence that these were inspected, either as a matter of routine, or at all. If they had been, at least in the late 1980s, the alleged abuses perpetrated by Jane and Alan Maguire would have been identified much earlier. We find it astonishing that in this FGH, a record was kept of punishments that the Houseparents apparently thought would be acceptable to Children's Services.

Les Chênes

4.648 Most of the evidence concerning Les Chênes can be dated, and therefore given its context, by reference to the individual then in charge.

Introduction: context

4.649 Under the *Children (Jersey) Law 1969*, the Education Committee was required to ensure that adequate provision was made for the care and custody of young offenders. Principally the Committee was concerned with juveniles (under 16) on remand awaiting trial and those found guilty of criminal offences and committed to the care of the Committee by the Court. Les Chênes took over the remand role that had previously and controversially been designated to Haut de la Garenne. It was initially intended that Les Chênes should have both teaching and care staff.[806] At the outset Les Chênes was overseen by an Advisory Committee and subsequently by a Governing Body, although it is not immediately apparent when this changed. Following the designation of Les Chênes as a remand centre alone in 2003 (at which point it changed its name to Greenfields), the Governing Body was soon replaced by a Board of Visitors, modelled on the prison system. The Principal of Les Chênes was answerable to the Education Committee and the Director of Education until 2003. When care staff were introduced in late 2003, the newly named Greenfields was then overseen by the Health and Social Services Committee.

Tom McKeon (1977–1988)

4.650 Tom McKeon was the first principal of Les Chênes. He was principal from May 1977[807] to 1988. He had worked at St Edwards an Approved School in the UK – the last Approved School in the UK to close. The school did not have a secure unit. Children were placed in a dormitory on admission. While working there he remembers meeting John Rodhouse, Charles Smith and the President of the Education Committee who were fact-finding with the intention

[806] WD004268
[807] WD004271

of opening a residential school in Jersey. He was invited to apply for the post of principal at Les Chênes.

4.651 He told the Inquiry that his brief was "*to establish a residential school that would provide for children who were placed on remand by the Courts and who would require extended periods of residential care. That was about as far as the brief went*".[808] He was given what he described as a "blank sheet".[809] The original school was a farm property.[810] He was involved in the building plans. These included the construction of a secure suite, which he said followed "the Home Office Guidelines of the time".[811] The four cells that were built "met the requirements of the day".

4.652 Mario Lundy joined Les Chênes as deputy principal within a short time of the school opening. He told the Inquiry that there was a mistaken perception that Les Chênes was a children's home: it was "*an approved school and remand centre for young offenders and juveniles who were out of control*".[812] It had also been necessary to establish a school in the Island following the abolition of Approved Schools in the UK and the difficulty of making placements from Jersey into community schools with education in the UK.

<u>Management/Organisation</u>

Merit award scheme

4.653 Children were first admitted to the school in 1978.[813] Tom McKeon introduced a merit award scheme (MAS)[814] to Les Chênes – based on a system used in an assessment centre in Birmingham[815] – which the Advisory Committee referred to as a "*behaviour modification scheme*".[816] The minutes noted that his objective was:

[808] Day 77/9
[809] WD006487/2
[810] Day 77/118
[811] Day 77/119
[812] Day 74/8
[813] Day 77/10
[814] Based on a system used at an assessment centre in Birmingham
[815] WS000598/5
[816] WD006487/7

> "*not only to contain the children but also to modify their existing behaviour patterns*. *It is necessary to observe and record behavioural patterns and attempt to reinforce desirable behaviour and eliminate undesirable behaviour. One element of the programme is the Merit Award System whereby boys gain and lose points as a result of their work and behaviour … in the first two weeks a boy has no contact with home but can then go home at the end of every six weeks. However, if a boy has misbehaved and lost points he would lose that privilege. Children who cannot go home for various social reasons, could go out for the day with a member of staff, e.g. sailing or fishing. The boys need a break from Les Chênes from time to time, and must maintain contact with the community to which they will eventually return*".

4.654 When asked in evidence why contact with family was prohibited in the first two weeks Tom McKeon replied: – "*When I reflect on that I would say that was inappropriate. I cannot now see any reason why children were not able to have contact with their parents during that two week settling in period. It probably would have been advantageous to all concerned"*.[817]

4.655 The MAS system was set out in detail in an eight-page document dated October 1978.[818] The system allowed for rewards depending upon the number of points based on an assessment of behaviour by staff over any given day at the school. The most significant element was the *"leave programme*" which entitled a child to go home if he had sufficient points. Tom McKeon told the Inquiry that he had no regret over the choice of a behavioural model as against a therapeutic model; an educational psychologist and a clinical psychologist were available to provide support in therapy *"as and when needed*".[819]

4.656 When Les Chênes first opened, the expectation was that because the majority of placements were either remand or sent by the Courts, *"residents would not go home*". The Education Committee was opposed to home leave: it viewed Les Chênes as a junior prison – young people should serve a sentence and be released into the community at the end of the sentence. Tom McKeon told the Inquiry that he had *"to persuade them that the children should have regular consistent extended contact with the home and time away from Les*

[817] Day 77/87

[818] WD006487/235

[819] Day 77/15

Chênes. That's a very important part in developing the circumstances for their reintegration into the community. I do fervently believe that contact with family is an essential element of any residential care provision".[820] He believed that the MAS was effective during his time as Principal. In order to avoid points being awarded arbitrarily and inconsistently (a criticism made by Dr Kathie Bull 20 years later) Tom McKeon said that he reviewed daily the incident book in which points were recorded. Weekly staff meetings would include discussion about points. He accepted that there was inconsistency, "*we did all we could to mitigate the risks of inconsistency*".[821]

4.657 Mario Lundy agreed that when Les Chênes first opened the external expectation was that because the majority of placements were either remanded or sent by the Courts the residents *"would not go home*". He told the Inquiry that the MAS was a way of encouraging people to look at the treatment of offenders differently, *"you need to build on the relationships that exist between the young person and the community and their families*".[822] Mario Lundy would not be drawn on whether in fact the MAS was "one size fits all": *"Those young people were not placed at Les Chênes because there was an alternative approach, they were placed at Les Chênes because the referring agency felt that the approach that we had was in the best interests of those young people".*[823]

4.658 Tom McKeon did not accept that there should not be a link between going home and getting points: "*I think that the Merit Award System as it operated was fair and reasonable for the children and that they benefited from it and that there was a concept of progression through from a situation where there is a high degree of supervision to a situation where there is virtually no supervision*".[824]

4.659 Mario Lundy did not come across a teacher using the system in spite to punish a child and prevent them going home. Consistency was discussed

[820] Day 77/18
[821] Day 77/90
[822] Day 74/72
[823] Day 74/73
[824] Day 77/81

"*pretty regularly at staff meetings … the system was a framework … it was important to have conversations with people about why they lost points … what can we do to avoid this behaviour … you would always know if there was somebody at risk for not going home … you could take a child aside … we need to do something about that*".[825] It would have been unusual for a child not to go home. For Mario Lundy something would have had to have gone "*pretty wrong … Staff would be very keen on ensuring that young people got home at weekends*". In his view without the MAS, "*young people were more prone to arbitrary decisions being made by members of staff … we had pretty much eradicated that type of inconsistency*".[826]

4.660 Monique Webb recalls some staff being "*a bit fickle*" about the points system.[827] Some of the children went home regularly every weekend but others not so often: the majority went home more often than she would have thought: "*But I mean you could get home quite easily on the points system. As long as you kept your head down and you did your lessons and you did your cleaning and your bed and everything else the way you should it was quite easy to get the 350 or whatever points they needed".*[828] The MAS was in use throughout her time at Les Chênes. She found it a useful tool and that children generally knew how it worked "*they could see the sense in it*". She could not remember any child complaining about the system.[829] She never had misgivings about linking home visits with home leave, although now she understood the reasons why children should have been able to go home regardless. Some parents did not care less whether or not their children were at home. She thought the system worked well for the staff too.[830]

4.661 Jonathan Chinn (1982–2003) remembers the MAS being in use for the majority of the time that he taught at Les Chênes. When he first joined the school "*I think I must have shadowed somebody for the first week or first few days to see how it works*". The MAS would be discussed with students in

[825] Day 74/81
[826] Day 74/78
[827] Day 70/55
[828] Day 70/27
[829] Day 70/50
[830] Day 70/52

school assemblies, "*I think towards the end we took the negatives off, you could only have positive points*". He did think that MAS helped to modify children's behaviour. The Principal or Deputy Principal would know which members of staff were allotting points as their initials would have to be put against their entries.[831]

4.662 In 1987, the Principal's report to the Governing Body recorded that it was the tenth anniversary of Les Chênes. It noted that the MAS was on its "third major variation" and recognised that any system "*becomes more complex in its operation and less relevant to a particular group of children. It is essential that they identify with what becomes their system to the development of which they have made a significant contribution*".[832]

Use of restraint

4.663 Physical restraint was viewed "*very much as a last resort*" according to Tom McKeon:[833] only when a child "*represented a threat to himself or others would it be appropriate to restrain him and then to use the minimum amount of force necessary to hold the child".*

4.664 Monique Webb, who worked at Les Chênes for 16 years as a Matron and as a teacher, told the Inquiry that there was no guidance on how to deal with violent behaviour. If a situation did escalate there was a male teacher in the next room and she could call someone straightaway.[834] Tom McKeon never saw a member of staff hit a child but did witness a staff member pushing a child against a wall.[835] *"I just orally warned the member of staff and made a note on his file".*[836] Jonathan Chinn (1982–2003) thought that the first restraint training he received was in 2003. Until then "*we debriefed each other when restraint happened and talked about it and which was the safest and best way for the student*". He used his own initiative when devising a safe means of restraint, "*A sort of bear hug around the arms so [you] restrict the arms so the*

[831] Day 71/53
[832] WD006339/31
[833] Day 77
[834] Day 70/29
[835] Day 77/31
[836] Day 77/126

arms are not flying about. … de-escalation is the most important thing of working with these sorts of students because the last thing you want is to be restraining a student you have been spending 40 hours a week with, as a last resort".[837]

Use of corporal punishment

4.665 Tom McKeon told the Inquiry that, in his 10 years as Principal: "*corporal punishment was administered on about a dozen occasions and in the last three or four years, no corporal punishment was administered at all*". Its use was abolished by the Education Committee in schools in the mid-1980s.[838] He said: "*My view as of today is that corporal punishment is an inappropriate way of dealing with children's behaviour*".[839] He explained his approach to caning a child.[840]

4.666 Mario Lundy remembers corporal punishment being used but infrequently. He did not think it was effective; it built up feelings of resentment. He remembers that there would always be an adult present as a witness and that the caning would be recorded, setting out the number of strokes and the reason.[841]

4.667 Jonathan Chinn thought that corporal punishment went completely against the ethos of the school: *"We worked with the students and they were there 24/7 some of them. We were there to encourage them to move forward. We certainly were not there to punish the students – I think Les Chênes was probably ahead of its time, they did not want to use corporal punishment".*[842]

Use of the secure suite and secure cells

4.668 In 1983, Tom McKeon produced a paper: "Arrangements for children placed on remand at Les Chênes Residential School".[843] This document is significant as it reflects the rationale behind the use of the secure unit when children

[837] Day 71/15-16
[838] WD006121/55
[839] Day 77/ 66
[840] Day 77/72
[841] Day 74/150
[842] Day 71/61
[843] WD006504

were first admitted: "*The aim with child on remand has been to expose them to a process characterised by the establishment and achievement of behavioural goals, marked by the granting of rewards and enhanced status within the school*"…".*When children first arrive at the school 'on remand' or indeed on placement via other means, they are normally placed in the secure accommodation for the purpose of sleeping. In extreme circumstances, the 'secure suite' in conjunction with the ball court, could, for a short period of time, be used to 'contain' children who could not be integrated into the normal operation of the school. Once a child has settled in (showing a 'reasonable controlled pattern of behaviour') he was to be moved to one of the bedrooms 'in the main house'*".

4.669 The paper recognised that some children had been held on remand at the school: *"in excess of many sentences at the Young Offenders Centre … or at Prison".*

4.670 Tom McKeon maintained that the use of the cell on admission was not a means of control: "*I think it would have been singularly inappropriate for secure accommodation to be used in that way*".[844] In response to a Panel question, Tom McKeon reflected: *"I do not think you can resolve a problem by locking it away … on the very odd occasion when children were locked away because of their presenting behaviour it was something that caused me great anxiety".*[845] Tom McKeon agreed that locking a child in on the first night was to both prevent them running away when short staffed and to make the child feel secure: "*in the absence of any constant staff presence to provide security for the child you had to lock the door and that was at a time when the staff presence was at its minimum*".[846] How that made the child feel secure depended on how it was managed, he told the Inquiry.[847]

4.671 Children on welfare placements were not placed in the secure unit according to Tom McKeon, only those on remand: other children would be placed in one of the bedrooms. When passages of his statement were put to Tom McKeon

[844] Day 77/94
[845] Day 77/135
[846] Day 77/136
[847] Day 77/154

describing CCOs *"dropping children off*" who would then *"sleep in secure*" he replied: "*To the best of my recollection it was only children who were on remand who would have been placed in the secure accommodation. There were very few children who came by alternative routes at that particular stage*".[848] He was asked to respond to the evidence of WN651 who in 1986 spent his first two weeks on admission (not on remand) in a secure cell at night where he felt scared and isolated. It was not an account that *"resonated*" with Tom McKeon, but he could understand how a child might be distressed from being away from home: "*and sleeping in a secure room may well have caused a degree of distress … I'm not aware of any child who experienced difficulties with that and I attribute that to the sensitive way in which it was managed by members of staff".*[849] The rationale for staying in the secure suite was *"to get to know the child, to make sure that the child was settling in reasonably well, to try to determine were there any problems of interaction between the child and other children … the process we adopted seemed to work perfectly well for the children … it was never seen as punitive".*[850]

4.672 Mario Lundy said that on admission children would undergo a six-week assessment which included an assessment by an educational psychologist addressing the child's therapeutic needs. A report was then put on the child's file.[851] It assessed educational position, attainment, educational needs, relationships with staff and other pupils, family relationships, and any changes that occurred.[852] He believed that a number of young people at Les Chênes needed more than periodic assessment by a psychiatrist and probably needed a bespoke programme of therapy.[853]

4.673 Over 20 years later, Dr Kathie Bull said that "*the use of the secure suite for all young people on entry to Les Chênes is most unacceptable*". Tom McKeon agreed but said what had changed since his time as Principal was *"an increasing number of youngsters that have been placed on voluntary order …*

[848] Day 77/52
[849] Day 77/55–56
[850] Day 77/55
[851] Day 74/17
[852] Day 74/257
[853] Day 74/260

whose presenting problems were of a psychological rather than an offending nature … The nature of the placement had significantly changed over time".[854]

Use of the secure accommodation as punishment

4.674 Tom McKeon could remember only "*two or three times*" when it had been necessary to use the secure accommodation because of a child's behaviour. He did not think it was appropriate, adding "*that's probably why it was used so very sparing*ly". It is not clear whether he thought it was inappropriate to use at the time.[855] Monique Webb could not remember the cells being used for punishment "*ever*".[856] Jonathan Chinn remembers that in the early days when he joined "*the secure suites would go months without being used … they were used for storage at one point [and] as a games room for a massive Scalextric set*".

Staff: rules and routine: culture

4.675 In 1978, Tom McKeon produced a Handbook for the school.[857] The Handbook pages 175–180 set out a timetable from 7.30am until 10.30pm, with the evening routine delineated 4.30pm–4.40pm–4.55pm–5.20pm–6.15pm–8.00pm–8.30pm–8.45pm–9.00pm–10.30pm. Also included are procedures on handover, night supervision, clothing as well as a separate section ("Part Two") on the merit award scheme. The Handbook also provided guidance on the use of the secure rooms.[858]

4.676 Monique Webb remembers that the hours were longer than the teaching job she had had before:

> *"Those long days were hard going from 7.30 in the morning to 5.30 because you had to be acutely aware of what was going on around you all the time and by the time you had worked from 7.30 in the morning until 5.30 you had had enough by the time 5.30 came along. But I did not notice it much at the beginning, but the older I got I did notice it and*

[854] Day 77/57
[855] Day 77/67
[856] Day 70/57
[857] WD006326/147
[858] WD006326/185–187

then the next day you did not come on until 5.30 and then you were on until 10.30".[859]

4.677 She told the Inquiry that was very happy at Les Chênes and had enjoyed her job.

4.678 Jonathan Chinn would teach on two days during the week and worked in the evenings on two days doing activities and sport. He would have one day off. At the weekend he would normally work both days – "*general management*". The school drew on supply staff which he felt was a "*bonus"* to the school.[860] On the evening shift there would be three staff; only in later years did the number of residents go up to 20 and then it had an impact on the activities in the evening.[861]

4.679 For Derek Carter, "*the routine was strict in term time because we had to commit to certain times for lessons … in the evening the priority was to get the children settled before the night staff came on*".[862]

4.680 Tom McKeon remembers that he visited most families on a termly basis,[863] he provided parents with regular progress reports and he welcomed visits whenever parents wished. He told the Inquiry that in a week there would be anything "*between three and half a dozen occasions when parents would come to the school*". There was a sitting room for visiting families and they could wander round the grounds.[864] Although parents could come any time, "*not many of them did mind you*" recalls Monique Webb, although the visits were welcomed by staff.[865]

4.681 Tom McKeon told the Inquiry that when the school started *"the vast majority who were employed at Les Chênes were … teachers*"; they had qualifications and experiences related to child development and support. Staff at the school *"had worked in special schools, with children with special educational needs*

[859] Day 70
[860] Day 71/25
[861] Day 71/43
[862] Day 96/93
[863] Day 77/7
[864] Day 77/143
[865] Day 70/26

or in Community Homes in the UK. It was difficult to recruit the right staff at the outset" because of the pay offered and there were fewer holidays.[866] In his 1979 Report to the Advisory Committee he said that *"these factors leave us some considerable way behind similar schools in the UK and could well continue to create considerable problems in the future".*[867] He subsequently negotiated better terms and conditions for teaching staff.

4.682 In 1987, Tom McKeon wrote to John Rodhouse, the Director of Education agreeing with John Rodhouse's concerns that care and teaching were becoming separate which Tom McKeon saw as "*most regrettable*":

> *"One of the great strengths of the school is that we have a staff, composed predominantly of teachers, who undertake a combined commitment to the educational and social programmes of the school. They use the skills of the teacher not only in the classroom but throughout their varied contacts with children. I am personally convinced that it is only because of the qualities and experience of such staff we can make progress with those children who have proved difficult to even contain in a wide range of settings".*[868]

4.683 In evidence to the Inquiry, Tom McKeon recognised that as "*the nature of children or the nature of children presenting problems changed there was a greater need for people who were specialist providers of care*".[869]

4.684 Mario Lundy said that the idea of an all teacher staff was to promote consistency in terms of standards and expectations of behaviour rather than having care staff in the evenings as happened with similar models in the UK.[870] Teachers at Les Chênes had to be prepared to work long hours and sacrifice traditional teacher holiday periods.

4.685 When asked to explain why WN246 continued working at Les Chênes with young people despite the fact that Tom McKeon had had to reprimand him for striking a child and in the light of what was known about him, he said:

> "*It could be argued that sufficient steps were not taken, that this individual should have been removed from the service immediately …*

[866] Day 77/24
[867] WD006487/13
[868] WD006679
[869] Day 77/14
[870] Day 74/24

> *He had many good qualities which he exercised on behalf of the children and was going through a very difficult and traumatic time in his life so needed to be supported as well as disciplined".*[871]

4.686 In January 1979, there were eight members of staff as well as the Principal. They taught both academic and non-academic subjects and outdoor activities.[872] There were weekly staff meetings.

4.687 Derek Carter joined the staff in 1980 and worked at Les Chênes and subsequently at Greenfields until 2006. He was a qualified teacher in handicrafts. Jonathan Chinn had been a PE teacher in England and joined the staff in 1982. His job description included some management responsibility. He was a Team Leader in charge of a shift but received no formal training.

4.688 Monique Webb told the Inquiry that there was no formal process for staff complaints. Tom McKeon agreed "*people had to exercise their own judgements".*[873] Ms Webb was the only female residential staff member in the 16 years she worked at the school. She recalls no difficulty keeping discipline in the classroom "… *lovely kids … I think they knew I liked them*".[874]

4.689 Jonathan Chinn said: "*the majority of the students were fantastic*" although some were very difficult, "*violent, aggressive, unpleasant*".[875]

Relationship with Children's Services

4.690 This was an ambivalent relationship according to Tom McKeon. Some CCOs were enthusiastic, others questioned whether Les Chênes was suitable for its purposes. Some were hugely effective in their contact with the school and families, others had to be encouraged. He never got the sense that Les Chênes was marginalised by Children's services. In a paper, "*Role of CCO Les Chênes Residential School*", dated May 1979, Charles Smith set out how the relationship between the school and the CCO should work in practice, concluding that the CCO who "*knows the family will continue to be*

[871] Day 74
[872] WD006487
[873] Day 77/36
[874] Day 70/34
[875] Day 71/32

responsible for the child at Les Chênes".[876] The key worker system was not adopted at Les Chênes.

4.691 Staff recollections vary. Monique Webb remembers the CCOs bringing welfare placements but that she rarely saw the CCOs, and was never asked for her input when it came to planning for the child.[877] Jonathan Chinn recalled CCOs being in the school "*a lot*" as were Probation Officers.[878]

Culture

4.692 Tom McKeon said that he and Mario Lundy shared a similar ethos; both had been assertive and robust. His ethos was *"structure and discipline*",[879] there were *"high expectations of children's behaviour … respect of children, respect of staff by the children that had to be applied with rigour. That's what I mean by 'robust'*".[880] He considered that the balance of being robust but not excessive had been "appropriate" and that intervention *"should conclude with some proper discussion about what had occurred … and what needed to happen to prevent it happening in the future*".[881]

4.693 Mario Lundy said that when he first joined Les Chênes "*education was at the forefront … It was also about trying to help young people modify their behaviour and give them a period of stability where they were not offending, so that they can enjoy a better quality of life*".[882] He remembers that although in the "*early days*" there were bars on the window the Principal had these removed*, "it was not the type of culture and ethos that we were trying to create. The idea was that for the most part security would be managed by good relationships between staff and young people … the outside doors were locked".*[883]

[876] WD006326/38
[877] Day 70/62
[878] Day 71/71
[879] Day 77/28
[880] Day 77/68
[881] Day 77/68
[882] Day 74/12
[883] Day 74/124

4.694 Monique Webb said that the school was run as a tight ship "… *an emphasis on keeping order in your classrooms … not an awful lot of emphasis on the emotional needs".*

4.695 John Pilling visited Les Chênes in 1980. His perception was that at that time most of the residents were there on care orders. He recorded his impression of the culture:

> *"Once inside, the strong impression is the certainty of purpose about the establishment. Doubt about what to do does not seem to exist … and everything is linked to a points system … Within this certainty of purpose there must be advantages for the children who have to live there. There is no doubt in their minds about what happens, and the predictability of what will happen – do X and Y follows. On reflection, I wonder if the system practised at Les Chênes operates from the same base as that practised at Haut de la Garenne. Both systems emphasise the efficiency of group control; both systems could be in existence more to meet staff needs than children's needs. I cannot, for example, accept that home visits can ever be related to points of behaviour. Some children NEED home emotionally and failure to recognise this is, in my opinion a lessening of the professional task with which educationalists are charged".*[884]

4.696 Tom McKeon commented that John Pilling's views were those of a "*field social worker*" from a different position on the spectrum of social care from those responsible for managing Les Chênes. He believed that "*the approach that I developed and that we adopted and maintained at Les Chênes during the time that I was principal was entirely appropriate … it was appropriate in its day".*[885]

4.697 Mario Lundy did not think that John Pilling's concerns were justified, even though he agreed that at that stage most of the residents were on care orders: "*some of the people who came to Les Chênes [on care orders] were actually beyond the control of their parents at home, so it was not a very satisfactory relationship at home, it was important for us to rebuild that*". John Pillings' concerns did not cause the school to amend the MAS.[886]

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[884] WD006487/70

[885] Day 77/84

[886] Day 74/85

4.698 Tom McKeon would not be drawn on whether he agreed with Dr Kathie Bull's view that "*denying visits home to those who are not on secure placement is very unacceptable practice*". He said that her point of view was "*valid*" and he understood it "*particularly with reference to the population that the school might then have been dealing with*".[887]

4.699 During his time as Principal, Tom McKeon thought Les Chênes was a *"dynamic*" institution – he told the Inquiry that he thought the school provided *"a very effective resource for young people and provided a great aid and support to young people*".[888] He felt that the work done at Les Chênes during the early years *"where we had great success with many of the children, was part of the culture that changed attitudes among politicians and other members of the community".*[889]

4.700 Monique Webb thought that the approach at Les Chênes when she was there worked:

> *" … things were different, and I thought that some of the things they used to say about their home life and how they used to stay up until all hours and all the rest of it, I think that on the whole the regime at Les Chênes, with the regular meals and everything, which by the way was something they did not get at home, I think on the whole they all prospered physically and did very well, you know. I think Les Chênes suited them".*[890]

4.701 In their 1981 report Lambert and Wilkinson commented on Les Chênes.[891] The premises were "*extremely suitable for their work*". The report set out the amenities and nature of placements, "… *the teachers were enthusiastic and able. Certainly the children seemed committed to their work and there was a noticeably diligent and creative attitude to educational tasks".* The report concluded:

> "*the establishment is providing a unique experience for the resident children, based on what appears to be a high quality of specialised education and on a very warm and committed approach to the children*

[887] Day 77/85
[888] Day 77/106
[889] Day 77/123
[890] Day 70/75
[891] WD007382/45

> *by the adults. The establishment is also very 'professional' in its task, having worked out its conceptual frame work in advance of operation, and consequently refining practice within this frame-work. This appears to have led to a security and sense of purpose which is shown by the behaviour and responses of children and staff alike …. We see an enhanced role for Les Chênes in future years, working with many more difficult children, especially those who are in care but not necessarily defined as delinquent in the narrow sense".*

Governance (i)

4.702 Les Chênes Residential School Advisory Committee held its first meeting in February 1977. It reported to the Education Committee. Members included Jurats, Youth Panel members and local clergy. The Principal of Les Chênes was accountable to the Advisory Committee. Minutes were confidential. Admissions were discussed and Tom McKeon recognised that by modern standards "*it would be quite inappropriate to share the names of these young people with the Committee*".[892]

4.703 During his time as Principal, Tom McKeon told the Inquiry that the Advisory Committee never inspected Les Chênes, although some did visit;[893] according to Tom McKeon, the attitude of some members and "*a fairly broad group of society in Jersey was that naughty children should be put away and kept away*".[894]

Mario Lundy (1986–1996)

Management and organisation

4.704 Tom McKeon resigned in 1988. His post was taken by Mario Lundy who had been the Deputy Principal since 1979. For a brief three-month period in 1985 Mario Lundy had worked at HDLG. He had qualified as a teacher in Manchester and then worked at St Edwards, the last remaining Approved School in the UK. Mario Lundy left Les Chênes in 1997 becoming Head Teacher at Grainville School. In 2004, he was appointed Assistant Director of

[892] Day 77/21
[893] Day 77/41
[894] Day 77/123

Schools and Colleges for Jersey before becoming Director of Education in the island in 2008.

4.705 At the time he took up the appointment, the total capacity of Les Chênes was 20 pupils of which four spaces were set aside for pupils from Guernsey. The staff included the Principal, Deputy Principal, two teachers, three teacher/care workers, one gardening instructor, two domestic staff, one night supervisor and 2.6 full-time staff.

4.706 During his time as principal, the numbers admitted to Les Chênes increased rapidly, particularly in the 1990s, following a revised admissions policy which allowed for a child to be admitted for long-term placement at Les Chênes: *"on the imposition of a Probation Order with residence at Les Chênes being a condition of that Order".*[895]

4.707 By 1991, there was pressure on the school from the Court *"to provide remand facilities for 16/17 year olds as there is inadequate provision in the Island now that the Junior Remand Wing at the prison has been closed".* The dilemma raised by the pressure was summarised in Governing Body[896] minutes for January 1991: "*Should these older delinquents be remanded to prison they could be subjected to the influence of convicted criminals. However, if they w*ere *remanded to Les Chênes their influence on younger more impressionable pupils would similarly be unacceptable*".[897] At the next meeting, the proposal appears to have been abandoned:

> "*A meeting was held in November 1990 between representatives of the Offenders Education Committee and the Prison Board to discuss the role of Les Chênes in relation to the remand of young people aged 16 to 17 years. It was generally agreed that neither the prison nor Les Chênes were appropriate for such remands but, until the Young Offenders Institute reopens, the school should continue to exercise flexibility in relation to immature 16 year olds and the Magistrates would carefully consider the use of a custodial remand in such circumstances".*[898]

[895] WD004214

[896] The successor body to the Advisory Committee

[897] WD006326

[898] WD006326/207

4.708 Peter Waggott thought that the probation order with a condition of residence *"in the beginning and for most of the 1990s … was pretty effective. No one seemed to have questioned the notion that probation is not a custodial sentence so those that were on probation orders did well, the vast majority of them".*[899]

Merit Award System

4.709 Mario Lundy told the Inquiry that the MAS was *"introduced to get children home, not to keep them from going home".* He recognised the two separate categories of welfare and remand placements but it would have been "*difficult to run two distinct philosophies in the same small scope … .the [welfare] placement was made because it was felt by whoever the referring agency was that this young person would benefit from the programme at Les Chênes"* including the MAS and home leave provisions. Children's Services were aware that children would not be allowed home for the first 12 weeks. This changed: "*as the school started to take more young people with emotional behavioural difficulties as opposed to delinquents, then the Merit Award System started to evolve … if you look at the later years the system got to the point where young people could actually work towards very quickly being day pupils*".[900]

4.710 At a Governing Board meeting in January 1990 Mario Lundy set out the aims of the behavioural approach represented by the use of the MAS:

> " … *we strive to encourage good behaviour and appropriate attitudes by rewards and sanctions available through the Merit Award System. In a primitive form this is no more than a management tool for staff but the system has changed significantly during the past year, becoming much more sophisticated. Fundamentally, there is now a greater emphasis on pupils accepting more responsibility, making decisions and recognising the consequences of those decisions. While behaviour modification and token economies have been around for some time, our particular adaptation of the concept is very effective and probably quite unique".*[901]

[899] Day 75/184

[900] Day 74/68

[901] WD006326/50

4.711 In 1991, the MAS was reviewed by HMI Sylvester who noted that the scheme had value but needed to be kept in balance and have flexibility. Mario Lundy agreed and told the Inquiry that this is what he established.[902]

4.712 Monique Webb thought that the MAS was less strictly applied under Mario Lundy than previously: *"In some ways a bad thing because the kids soon cottoned on and caused more trouble but in other respects not a bad thing I suppose".*[903]

4.713 WN834 remembered that during her time at the school (the first half of the 1990s) a pupil appraisal system was introduced that enabled pupils to earn time away from the school: "*The system allowed for a more regular pattern of home leave and … a clearer understanding of the system for pupils*".[904] In her view, the system also allowed: "… *for a fair, but punitive measure as well as a reward for prosocial and learning behaviour. For example, in negotiation with the pupils, a tariff was established of the number of points to be removed from an individuals' point tariff if they displayed aggressive behaviour or disrespectful language. The involvement of pupils in developing the pupil appraisal system was considered to be at the forefront of educational thinking by my professional colleagues on mainland Britain*".[905]

4.714 Kevin Mansell remembers that, for a small section of residents, the MAS was not an incentive as they did not want to go home: " … *just one or two who did not, and then we would start working with Children's Services, as it was at the time, to see if an alternative placement could be arranged. And actually we would work quite hard with the parents, to try to get the young people home".*[906]

4.715 In his statement to the Inquiry, Kevin Mansell gives the example of one resident who struggled to get sufficient points so that he had not managed to get home for six months. Kevin Mansell remembers going to Mario Lundy who allowed the resident to go home even though he had not got the points under

[902] Day 74/145
[903] Day 70/37
[904] WS000719
[905] WS000719/2
[906] Day 80/18

the system. Kevin Mansell told the Inquiry that the 11-year-old boy's situation had "*escaped people's notice*". He said that this was an exception and that the system was not inflexible – "*it was robust but there was always room for manoeuvre".*[907]

Secure accommodation

4.716 Secure accommodation was used for sleeping on arrival and according to Mario Lundy only remand residents were taken to the secure cells and locked in. The use of secure cells for "*time out*" did not "*happen often*"; he said that this reason "*phased itself out really".*[908] The unit was never, in his view, used for the convenience of staff. The evidence that children were kept in secure cells for days was, he said, fabrication – someone would have noticed had a child gone missing he added.[909]

4.717 The Les Chênes School Handbook 1990 stipulated that secure cells were only for sleeping children on remand and for medical isolation – the cells were not to be used for "time out" isolation or containment. Mario Lundy accepted however the possibility that after 1990 the cells may still have been used for this purpose.[910]

4.718 Kevin Mansell was invited to comment on the "*Les Chênes School – Handbook 1990*" and specifically on the secure accommodation section.[911] He could not remember getting the handbook when he started. His memory of what happened to children on admission differed to Mario Lundy's: "*When I worked there and Mario Lundy was head, secure was not really used … it was really only after Mario had left and that a new Principal had come that we started to receive a significant number of people from Court when that would be the case".*[912]

[907] Day 80/25
[908] Day 74/163
[909] Day 74/167
[910] Day 74/168
[911] WD006488/11
[912] Day 80/32

4.719 He thought that the first remand placement he remembered after having joined the staff in 1991 was in 1994. None of those admitted during that time were placed in secure: " … *they were placed in the bedroom next to the night supervisor's room upstairs*". He could remember only one incident when it was used to calm a resident down, and then only for 10 minutes: "*I remember going to get the young person because I was teaching them".*

4.720 Monique Webb remembers that children were only in a secure room at night: *" … they were not in there during the day. It was only at night. They were never kept in secure accommodation, they mixed with the other children during the day".*[913]

4.721 Peter Waggott, an English teacher who joined the staff in May 1989, was asked to explain his understanding of the rationale for placing a child on a welfare order in the secure suite on admission when the building itself was secure: "*It was simply as brief as possible a settling in period … They had come from extremely chaotic and disturbed circumstances … A night of quiet and calm really would help them settle in".*

4.722 Peter Waggott remembers that young people could be sent to the school on secure remand: "*These residents were not allowed out of the school and would be taught lessons in the secure vestibules. In the early days all remands were under the same regime of sleeping in non-secure rooms and being educated with everyone else".*[914]

4.723 The Principal or Deputy would decide when to move a child out of secure following admission.[915] Later in his evidence, and in a different context, when commenting on the fabric of Les Chênes by the early 2000s, Peter Waggott was sceptical about the building being secure: "*The secure unit had been built in 1976 when the school was opened … by 2003 Home Office spec was way beyond what we had and the security of the rest of the building was pretty much like anyone's house.*

[913] Day 70/61
[914] WS000591
[915] Day 75/161

> *It was an old farmhouse with standard double glazed windows, ordinary doors … there was not anything secure about it at all".*[916]

Jonathan Chinn recalls that by the 1990s, when the suites came to be used more, they were quite dated but that they remained a "*safe environment*":

> "*The students would be put there perhaps if they had come back on drugs, etc, or they were coming down. Perhaps if they had been very confrontational perhaps with another student, or they had been on the booze the night before and they just would have come into school and been a complete disruption. But the secure suite was just down from the teaching area so quite often the door was left open and they would just be sleeping in there".*[917]

4.724 WN834 recalled being shocked when she was left in charge that she had been delegated responsibility for the use of the secure suite, "*without reference to any other external personnel*". This arose when she had had to admit two young women from La Preference who *"had developed a pattern of absconding behaviour"*:

> "*Whilst most of the residents were male, the handbook made no reference to the non-admission of females, so both girls were admitted and a programme of social activities put in place to ensure that evenings and weekends when they did not have home leave, were filled with appropriate activities. The admission request came from Anton Skinner [Children's Officer] and he 'signed off' the plan for a programme of support prior to the arrival of both children".*[918]

Restraint

4.725 Mario Lundy told the Inquiry that there was no restraint training at Les Chênes. He had had none by the time he left in 1996 and that none had been offered. This accords with Kevin Mansell's evidence who joined the teaching staff in 1991: he says that the first training he received was in about 1998. According to Kevin Mansell, restraint training was not available prior to that in Jersey.[919]

4.726 As Mario Lundy characterised it:

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[916] Day 75/165
[917] Day 71/63
[918] WS000719
[919] Day 80/12

> "*Restraint did happen, there were quite a number of occasions over the 18 years when I was there when restraint was used, but it didn't characterise the culture of the school and you have two reports, perhaps more than two reports, but at least the Lambert and Wilkinson Report and I think another report from HMI who actually – they refer to the positive relationships and the behaviour and attitudes of the young people. That's what characterised the culture of Les Chênes, not restraint, but restraint was used*".[920]

4.727 He told the Inquiry that he recognised that, on occasion, he had to be assertive and robust although he added that this was not part of the general culture of Les Chênes, *"I stood my ground when I was challenged … There would be times when I had to put a hand out and push the young person back and say 'back off',… times I would have pulled a young person away from another … times when I put my arms around a person and even wrestled them to the floor, and on a few occasions when there was a weapon involved I would always go for the arm that had the weapon".*[921]

Staffing

4.728 WN834 was a member of staff for two years in the first half of the 1990s. Her appointment was subject to a "*vigorous selection procedure*", part of which included being interviewed by students. This she considered to be one example "*of the progressive strategic planning that I experienced whilst working at Les Chênes".* One of her tasks was to help introduce a more holistic assessment of pupil need. There was an induction process for her on appointment.[922] She said she shared Mario Lundy's concern about the quality of staff "*who might be working with vulnerable children but without a professional background qualification*". She said (speaking of the time around 1994) that qualified social workers, youth workers or mental health workers could not readily be found on Jersey.[923]

4.729 Mario Lundy remembers at the time that many residential care staff were unqualified and that by contrast teachers would have been through some training but he recognised with hindsight that there was not sufficient training.

[920] Day 74/31
[921] Day 74/155
[922] WS000719
[923] WS000719/2

He remembers that while still Deputy he was sent on a training course in Birmingham after the Lambert and Wilkinson Report came out. The course was funded by the Director of Education.[924]

4.730 Peter Waggott joined the teaching staff in May 1989, as an English teacher. He had a PGCE in English and Physical Education. While working as a teacher in a comprehensive in Newcastle, he had gone on to obtain a certificate in the psychological management of disturbed children and adolescents at the Nuffield Clinic, Newcastle University in 1986.[925] He thinks staff at Les Chênes would have benefited from doing, as a minimum, the same sort of course.[926] He worked under Mario Lundy, and went on to work under WN109, Kevin Mansell and Joe Kennedy. When he joined there were eight staff covering both education and care.

Record keeping

4.731 Mario Lundy told the Inquiry that any significant event was recorded in a daybook; initially one central book, but later sheets for each child. Each child had a file to which staff had access. Kevin Mansell recalled as did others that each resident would have a file to which the staff had access.

Intake of pupils/admissions process

4.732 Aside from remand placements, children would be admitted by the Education Committee because they were beyond care and control of either their parents or other children's homes.[927] With voluntary placements, parents with disruptive children would have been made aware that Les Chênes was available as a facility. In such cases placement at the school, without the need for a care order, was made through a referral by Children's Services or by the educational psychologist.[928] Not every child would see the educational psychologist – it depended on the nature of the initial placement and if the child was already seeing one at the point of admission. The educational

[924] Day 74/27
[925] WD006416/3
[926] Day 75/131
[927] Day 74/22
[928] Day 7/23

psychologist would be called in when "*we had a concern we felt [he] could help us with*".[929]

4.733 In the early days of Les Chênes, when children were admitted they were would be given clothes. Children would wear a school uniform during the day. At a later stage they were allowed to bring their own clothes which they could change into after school.[930]

Absconding

4.734 When children went missing the school would inform the police immediately. Although the assumption was that the police would then handle it in practice it was often staff from Les Chênes who would return the young person. Once back the staff would talk to the young person to find out why they had absconded. Mario Lundy never had the police tell him on bringing back a young person that they had complained to the police about how they were being treated.

4.735 Mario Lundy remembered a period when the school had had to "*address*" absconding. He described the approach that was taken: "*most of it would have been about discussing the consequences of absconding*". He said that this was so successful such that in his time as principal, "*I opened all the doors so that it was no longer a secure school*".[931] He had not needed to consult the Courts because "*a lot of the kids at that time were on voluntary placements*".

4.736 In January 1990 Mario Lundy reported to the Governing Board that the main door of the school had not been locked during the school day for "*almost a year*" and there had been no absconding. He said that the school policy was that security be maintained through *"quality supervision and good relationships between staff and pupils*".[932]

[929] Day 74/58
[930] Day 74/112
[931] Day 74/127
[932] WD006326/50

Violence against staff

4.737 Mario Lundy was invited to comment on an account, recorded in June 2003, of residents threatening to attack staff. Did this happen when he worked at Les Chênes?:

> "*Not on a day-to-day basis. There were incidents at Les Chênes that were similar to this, some even more aggressive and violent, but it is easy to start thinking that life at Les Chênes was all like this, it was not, there were sometimes very difficult youngsters, very difficult situations, physical situations, aggression, violence, but as I say it did not characterise the school. There were many young people there who themselves would not associate with that and who did very well there and the culture and ethos of these young people was very good. It was a positive environment".*[933]

Contact with CCOs

4.738 Mario Lundy told the Inquiry that the frequency of visits to Les Chênes by CCOs depended on the individual CCO. They would come in the early days of admission then it would fall off, preferring to see the child at home. He had an expectation that the child would be seen regularly "*but that would not always be the case*". When asked if the CCO was not central to the welfare of children placed at Les Chênes, Mario Lundy suggested that:

> "*I think probably when the school had taken over the day to day work with the child they probably saw less of a role for themselves at that time. They were more about supporting the family … the main point of contact with the child on a day to day basis were the staff at Les Chênes".*[934]

4.739 Apart from the six-monthly review, CCOs would also come to speak to Mario Lundy about allocated children.

4.740 Peter Waggott's experience of Children's Services was a negative one: "*as teachers we did not have a valid opinion about the young people and we took exception to that … we spent sometimes 14 and half hours non-stop with these young people and you get to know them really well … When I went to*

[933] Day 74/121

[934] Day 74/63

case reviews … there was a feeling that everybody knew more than we did and better".[935]

4.741 Probation Officers were in the school "*on a weekly basis*".[936] Mario Lundy told the Panel that the Probation Officers would take part in the activities organised by the school.[937]

Culture

4.742 Monique Webb described Mario Lundy as a *"very powerful fellow who uses strength to defuse many a situation".* She assumed that he had had training: he would envelope them so that they could not hurt themselves or anybody else. He would try talking to them first but sometimes it just did not work.[938]

4.743 She recalled he would be rough at football and/or rugby matches and she, as Matron, was called upon to deal with injuries to the children. He was physical but only when warranted and there was no alternative.[939]

4.744 Mario Lundy responded that his *"roughness*" was not malicious but *"banter*" with the older residents as opposed to anything sinister. He accepted the description of himself as *"assertive and robust*" but not the account given by one witness that he would come out of the gym spoiling for an argument with residents.[940]

4.745 Mario Lundy expressed his frustration that records at Les Chênes had been destroyed as Les Chênes had been portrayed as an abusive regime when "*it was not" … "When I look at what was happening in England with detention centres, community homes with education on the premises, I felt that Les Chênes was light-years ahead of that and I think those day books would have reflected quite accurately the culture and ethos".*[941]

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[935] Day 75/180
[936] Day 74/64
[937] Day 74/245
[938] Day 70/39
[939] Day 70/41; Day 74/152
[940] Day 74/152
[941] Day 74/107

4.746 Peter Waggott remembered Mario Lundy as being "*much more hands-on head*", adding, "*He was around a lot. He interacted with the students a lot. He was available to speak to pretty much whenever you needed to … I think he's a great ideas man and he was always coming up with new ideas and visions and approaches of how we might do things, but he did not so much as impose them on you as suggest this might be a good way forward and then we would discuss it at a staff meeting and quite often".*[942] Mario Lundy believed that "*education had huge spin-off value for the residents at Les Chênes and I think we was right … Mario was keen to see the academic side of the school grow".*[943] When just starting at Les Chênes he remembered Mario Lundy telling him that relationships with young people at Les Chênes, "*is the key really to everything and if you can establish good relationships with them then everything flows from that".*[944]

4.747 Jonathan Chinn remembers Mario Lundy as "*very fair, very straight, firm, assertive*".[945]

4.748 Kevin Mansell did not agree that the ethos when he first joined was predominantly one of physical activity. For a child who did not enjoy physical activity: "*they would be given things to do they would be given opportunities to go into the workshop. Some young people spent absolutely hours in the workshop, making coffee tables, chairs, making things to take home they absolutely loved it. Other young people were given the opportunity to do cooking*".

4.749 WN834, who taught at the school in the first half of the 1990s, believes that the school was "*well managed, staffed by appropriately trained and supervised teachers who acted with professional integrity. The unconditional positive regard for residents was paramount in the work*".[946]

[942] Day 75/137
[943] WS000591/3
[944] WS000591; Day 75/133
[945] Day 71/118
[946] WS000719/4

WN109 (1996–2000)

4.750 WN109 was a member of staff at Les Chênes from 1995 to 2000. In his first year he had worked as a senior member of staff under Mario Lundy. He had received training as a teacher in child protection. In late 1996 Mario Lundy went on secondment to Canada, leaving WN109 in charge until April 1997. In fact, Mario Lundy was appointed Headteacher at Grainville School in the interim. WN109 remained in charge assisted by Kevin Mansell.

Management/organisation

4.751 Derek Carter told the Inquiry that WN109 was good and supportive to work with. The Home felt more relaxed during the time that he worked with WN109.[947]

4.752 Strains over the type and number of remand placements and the approach of the Courts were apparent during this period. This is highlighted by WN109 in December 1999 in a letter to Tom McKeon (then Director of Education) about the Magistrate's decision to remand a young person notwithstanding the Court being told that Les Chênes was overcrowded.[948] In February 2000 WN109 wrote to the Chief Probation Officer saying that the population was in excess of that which was intended and asking Probation "*to consider alternative methods of dealing with those who breach their Probation Order or are continually offending at a low level".*[949]

Restraint training

4.753 WN109 says that the staff did receive restraint training from Prison Officers. The only child he had had to restrain was a 15-year-old girl who was having a temper tantrum and had hold of a cutlery knife. He had held her by the forearms and told her to drop the knife which she had done.

4.754 Kevin Mansell, in his capacity as Deputy Principal, investigated what restraint training was available during this period. He recalled that Strategies for Crisis

[947] Day 96/154
[948] WD007366
[949] WD006902

Intervention and Prevention (SCIP) training was provided for Les Chênes and other institutions in Jersey.[950] He was able to compare SCIP with Therapeutic Crisis Intervention (TCI), "*I think SCIP was more aimed or targeted at younger people …10, 11, 12 year-olds … the school was taking in more and more 14, 15, 16 year-olds who had been remanded by the Courts for violent offences and so needed a form of managing behaviour which was more appropriate to the age and size of the people we were now dealing with".*[951]

Discipline: points system

4.755 WN544 remembers a points system being in place when he joined the staff in 1998. Though complex, it was "*very effective … the lack of conflict there was quite staggering considering we had some quite tricky kids*".[952]

Secure rooms

4.756 WN109 remembers that the secure rooms were "*officially called cells*" but that he did not like the term and always referred to them as "*secure rooms*". Although there were four, only three were used "*because one did not have a window and so the fourth was used as a store room … A window and speaker was inset into each of the doors. The only item in the room was a vinyl covered mattress which was covered in normal bedding. There was no toilet in the rooms".*[953]

4.757 WN544 recalls that the "detention rooms" were never used for punishment and were very rarely used when he first started. He remembers that those on remand would often be given a "*proper room*" straight away, "*only difficult/agitated children were placed into secure but we wanted to move them out as soon as possible*".[954]

[950] Day 80/12
[951] Day 80/14
[952] WD006631
[953] WD006141
[954] WD006631

Staff and non-staff view on the operation and culture of Les Chênes

4.758 WN109 remembers that new staff would have plenty of "*school sense*" but not what he described as "*secure accommodation*" sense. By way of example WN109 would tell staff that children would have to go in the back of a vehicle when it was being driven by a sole member of staff; whenever he had to speak to any of the girl residents in an office "*he always left the door open and ensured that his secretary was outside so that she could see and hear what was going on*".[955]

4.759 He felt that the culture of the school came from Mario Lundy's time as Principal. He said it was to be always very clear, to be very structured and to involve a lot of humour.[956] He remembers that Jim Hollywood, an Educational Psychologist, would be a *"regular visitor"* to the school who would be encouraged to *"eat and mix"* with the residents.[957]

4.760 WN544 started working at the school in 1998, providing both academic and non-academic teaching. He was at the school for five years. He saw the school in this period as "*a sort of holistic home for kids with a remand wing*". He thought this approach was "*very effective*": the curriculum was very broad "*which was what the students wanted: an outward looking approach to which they responded well*".[958]

4.761 Kevin Mansell told the Inquiry[959] that as Principal, WN109 was academically rigorous and proactive in *engaging* other agencies with the school; counselling services were provided; there were more visits from educational psychologists and Probation Officers and also more contact with Social Services and outside schools. Training was provided and he recalled "*lots of staff going away on courses and coming back into school*". Training was sought out: "*I remember lots of staff going away on courses and coming back into school*". He said that WN109 was strict but had a good relationship with the young people.

[955] WD006141
[956] WD006141
[957] WD006141
[958] WD006631
[959] Day 89/128

4.762 Kevin Mansell provided a rationale as to why there were no allegations of physical abuse in this period: "*I think young people related well to* [WN109] *… but also it was a time of change within the school. There was a lot of positive things happening. That is not to say positive things were not happening under Mario Lundy but, you know, there were a lot of investments in this area, we had different staff coming in, some younger staff were being appointed. And so it was a different environment.*[960]

4.763 In Tom McKeon's view, Les Chênes had lost its way by the late 1990s: *"it had reached the stage where it was reacting to circumstances, reacting to pressures, rather than pro-actively developing programmes that were agreed by all stakeholders".* He described the school as "*falling apart".*[961] When asked why it then took until 2003 for effective action to be taken, Tom McKeon described the additional support provided the school *"with a view to it becoming stabilised"* but that "*this was a slow process of decline and the interventions proved to be inadequate to prevent that decline from gaining pace".*[962] He thought by then and given "*the intensity of the challenge"*, the school was "*incapable of providing an appropriate response and that is why the provision that is made today and that was made shortly into the 2000s was of a very different nature*".[963]

4.764 Tom McKeon described the situation at the school at the time, "*And you had this situation where* more *and more children were being placed on Voluntary Care Orders, with the agreement of the parents, fewer and fewer were coming through the Court route, so the process was beginning to become blurred. Then there was a particular spate of challenge at the turn of the century, a lot of young people committing offences and more and more children being placed on remand, more children than certainly I ever experienced during my time as Principal of the school, to the point where the Magistrate was requiring these children to be held in secure placement and there were insufficient secure placements actually available at the school … I think the*

[960] Day 80/44
[961] WS000598/26
[962] Day 77/96
[963] Day 77/107

problems associated with the pressure caused by that very significant number of children who were being placed at Les Chênes created problems that … the institution was unable to withstand".[964]

4.765 The issue of overcrowding at Les Chênes, which continued into the early 2000s, is discussed further below.

Kevin Mansell (2000–2003)

Management and organisation

4.766 After graduating from university in London, Kevin Mansell worked in outdoor centres in Wales where he said he gained "*some residential care experience*". He completed a PGCE and a Master's degree in special education at Sheffield University before coming to Jersey in 1980 to teach at Le Rocquier school. He joined the staff at Les Chênes in 1991, as a geography teacher, although he had had previous contact with the school in helping with canoeing. For Kevin Mansell teaching at Les Chênes was appealing: *"whilst the role required forty hours of work per week staff were only expected to teach for two days. This meant that a large portion of the role involved the provision of extracurricular support and care during evenings and weekends".*[965] In 2000, he was appointed Principal.[966] He thereafter presided over what staff describe as a particularly difficult period for the school. The evidence suggests that this was due to a combination of factors coinciding, including:

4.766.1 the approach adopted by the Court in ordering remand placements;

4.766.2 a particular cohort of young people with emotionally demanding behaviour being placed in the school;

4.766.3 the adequacy of training for teaching staff in meeting the challenges presented by the large number of remand placements;

4.766.4 the increased population and overcrowding in the school;

[964] Day 77

[965] WS000599/3

[966] WS000599; WD006488

4.766.5 the role of the Board of Governors and the Director of Education.

4.767 Evidence from staff working at Les Chênes during this period highlighted the fact that they were reacting to what was happening rather than proactively managing the school.

Use of the secure cells/suite

4.768 Staff remember that the cells were used in this period: there were log books;[967] the cells were checked when occupied;[968] residents were placed in the cells "*for their own safety and the safety of others*".[969] Several describe a vinyl mattress ("*gymnastic type plastic mattress*"), a duvet, pillow and nothing else in the cell. There was an intercom.[970]

4.769 Kevin Mansell remembers that the cells were increasingly used from 2000 onwards for new arrivals who had been drinking or taking drugs and not been eating well – the provision of the secure suite and cell would allow them to rest, eat well and to sleep. He explained why in those circumstances at night time they would be locked in the cells, "*they would be monitored by the night staff*".[971] In response to Dr Kathie Bull's finding that all young people began their time by being placed in secure, Kevin Mansell told the Inquiry that by the time her report was written, "*welfare placements on a residential basis had pretty much ceased because of the number of people that were being remanded from Court*".[972]

4.770 Kevin Mansell agreed that by the 2000s "*when we had no financial support to buy in the staff that was needed"* residents on remand were placed in the secure suite while staff meetings took place. The practice was stopped he thought in 2001, but he recognised that it was inappropriate to use the secure facility in this way, and notwithstanding that the level of supervision was

[967] See, e.g., WD006154
[968] See, e.g., WD006128
[969] See WD006154
[970] See, e.g., WD006127; WD006135
[971] Day 80/36
[972] Day 80/36

increased when this happened, as it was effectively being used to "*control and contain*".[973]

4.771 An analysis of the use of the secure cells between 2000 and 2006 concluded:

> *"As every member of staff stated, the secure system was a difficult system to operate and was just as unpopular with the staff as with the residents – space was at a premium, extra staff were needed to monitor/control residents, longer hours were spent outside the classroom (after all they were teachers and not social worker/jailers)".*[974]

The Magistrate's Court and the Governing body: the crisis at Les Chênes

4.772 The approach adopted by the Magistrate's Court in the early 2000s in sending young offenders to Les Chênes put considerable pressure on the school. As suggested earlier the pressure had begun to build in the late 1990s. An analysis of the minutes of the Governing Body suggested that overcrowding was due to the increased number of young offenders placed at the school and the increase in school leaving age from 15 to 16 and a perceived change in the approach of the courts appeared increasingly willing to send young offenders to Les Chênes.

4.773 In February 1997, the Governing Body noted the concerns about the shortage of places at Les Chênes: "*Mr Birtwistle voiced his concerns in respect of the shortage of places as Les Chênes is currently being filled by the Courts and Guernsey were continuing to use all their places. Mr Birtwistle felt that children at risk needed to be placed in Les Chênes before the age of 15. It was agreed that the raising of the school leaving age had contributed to the shortage of places available at Les Chênes. Following further discussion, it was decided to hold a special meeting to discuss the increasing pressure on places at Les Chênes and to draw up proposals to help alleviate the situation for submission to the Education Committee*".[975]

4.774 A report on pupil numbers in 1997 indicated that a Magistrate, Mr Trott, continued to remand children to Les Chênes even when advised that there

[973] Day 80/39
[974] WD006188
[975] WD004230

were no available beds. A further meeting of the Governing Body in 1997 identified the increasing number of referrals as a "*continuing trend*" and that the "*shortage of places was likely to continue*". It was agreed that a statement be prepared "*for the Education Committee from the Governors expressing their concern in respect of the unreasonable pressure staff experience when too many severely damaged youngsters are placed in a small environment*".[976]

4.775 In March 2000 Magistrate Ian Le Marquand wrote to the Governing Body expressing his view that all remands of those under 16 years of age should be accepted at Les Chênes. He also set out his concerns about the school's dual role as both a provider of education and a secure remand facility.

4.776 In November 2000, the JEP published an article on overcrowding at Les Chênes, prompting Ron McLean, the Chairman of the Board of Governors, to write to the Director of Education:

> "*The Magistrate's letter [published in the JEP] has made public something that we (the Board of Governors and the Education Committee) have known for some considerable time – the School is overcrowded and the situation is not going to improve. We may have the Magistrate's sympathy and support, but he has no alternative in Law other than to remand young people to Les Chênes – the fact that we cannot accommodate them is not his problem. The Board has minuted a resolution that I write to you expressing its deep concern at the overcrowding situation at Les Chênes".*[977]

4.777 In December 2000, the Governing Body wrote to the Director of Education (Tom McKeon) alerting him to their concerns about overcrowding.[978] Kevin Mansell told the Inquiry (as did other witnesses) that at this time "*there was a small group of young people who are committing a significant number of offences … we are probably talking about ten or twelve*". Pressure was consequently placed on Les Chênes to provide additional secure accommodation. The school had no control over admissions and from 2002 regularly exceeded the maximum occupancy level; it was by this time no longer taking welfare placements.[979] In response to the overcrowding, "*some*

[976] WD004227
[977] WD004237
[978] WD004237
[979] Day 80/47

people had to be sent home. Completely inappropriate, you know, hot-bedding should not happen".[980]

4.778 Kevin Mansell told the Inquiry that he met with the Magistrates on several occasions. He was told that Les Chênes was the designated remand facility for those of school age and that if they needed to remand somebody then they would. As Principal he was not in a position to refuse placements which had been ordered by the Court.

4.779 The Principal's follow-up report to the Governing Body noted: *"Two issues of immediate concern are the increased number of remand cases followed by the length of time that it takes for cases to be resolved e.g. a number of students have been on remand for over five months which is totally inappropriate. At the present time there is very little that can be achieved in relation to the remand eases as those numbers merely reflect the fivefold increase in the number of young people who have appeared in Youth Court in recent years. The magistrates are actively looking for ways to reduce the length of remands that some young people are on, which may be of benefit to the school".*[981] A subsequent report recorded 23 students on the roll during March 2001.

4.780 Kevin Mansell told the Inquiry that cases where children were remanded could have been dealt with more efficiently and that alternatives to custodial remands should have been explored. The Probation Service was aware of the pressures on the school – he said that he probably spoke to them on " *a daily basis*". One significant consequence of Dr Kathie Bull's Report in 2001 was the removal of Probation Orders with a condition of residence.[982] Kevin Mansell remembered that that *"did ease the situation significantly*".[983]

4.781 He recalled that, following one meeting in 2001, the Magistrates had accepted his invitation to visit Les Chênes, following which they concluded that Les

[980] Day 80/47
[981] WD006416/18
[982] Day 80/57
[983] Day80/57

Chênes was not suitable for the most severe cases and "*insisted that certain young people were kept in certain areas".*[984]

4.782 Minutes of a Governing Body meeting in October 2001 also record the dilemma facing the school at the time (by which date the Bull Report had recommended that Les Chênes become a remand unit only): "*When WN627 had appeared in Court for sentencing the Magistrate would not accept the recommendation of probation and attendance at anger management and pitstop as it was felt this was insufficient. This sentence was the maximum that could be imposed whereas if WN627 had been an adult he would have been facing a one-month prison sentence. The Magistrate had therefore remanded the case for another week in the hope that an alternative recommendation could be made. Bail was not granted, as he believed WN627 was at risk of re-offending. The Governors were advised that in the past WN627 would have been returned to Les Chênes on a condition of residence but now that the school was a remand unit only this was not possible and there was no other provision in the Island. It was agreed that this gap in provision, together with the role of Les Chênes, should be discussed as a matter of urgency but would not solve the current problem"*.[985]

4.783 The approach adopted by the court and the effect on Les Chênes was summarised by Peter Waggott in this way:

> *"… under the age 15 a young person could be remanded into custody but not sentenced to custody … there was a sense with a few of the young people … they were habitual offenders … that they needed locking up, but they could not be given a custodial sentence so they were held on remand and then they would go to Court … sentencing was delayed because it was a requirement for a background report, or a probation report or a psychologist's report and so these inevitably took time and sometimes I think that it was the case that it took a lot longer than it should have".*[986]

4.784 An example of the length of remand placements imposed by the Magistrates is found in the case of WN73.[987] Peter Waggott told the Inquiry that WN73

[984] Day 80/55

[985] WD004264/54

[986] Day 75/150

[987] Day 56; see also Appendix 2

spent *"a great deal of time*" in a secure area of the school.[988] He agreed with WN73 who said that at that time the secure units were being used for far longer than had previously been the case.[989] Peter Waggott's view was that young people were placed on long remands for *"spurious reasons and there was no doubt in my mind that the Court did this as a punitive measure".*[990]

4.785 Peter Waggott told the Inquiry that in the early 2000s the Court had brought in different categories of remands (used for instance in WN73's case):*"Secure 1 was someone who has to be kept separate from the rest of the student population and only both sleeping and educated within the secure vestibule area and that was difficult because you were locked in with one or two students, not in a classroom, so you did not have any of your teaching resources … very often you were one-to-one with that person and if they were being difficult you were a little bit exposed".*[991] Peter Waggott explained that "Status 1" remand and "Secure 1" remand was the same thing. It meant that children were kept separate for both sleeping and education within the secure unit. Secure 1 remand was used for those guilty of a number of repeat offences rather than a single serious offence, while Secure 2 was imposed "*things like assault … breaking and entering*".[992] He thought that the categorisation was brought in by Ian Le Marquand,[993] while Kevin Mansell thinks it was started by his predecessor, Magistrate Trott.

4.786 Peter Waggott remembered that those on long periods of remand would sleep, be taught, and would eat in the secure area and exercise in the ball court: *"they were not totally cut off … Because we were concerned that they were spending so much time within the four walls of the secure area we set up a room … we had a computer in there and a games console and a TV".*[994]

[988] Day 75/51
[989] Day 75/152
[990] WS000591/6
[991] Day 75/146
[992] Day 75/182
[993] Day 75/156
[994] Day 75/155

4.787 WN73 said that as a "Status 1" remand admission he was not allowed out of the secure suite under any circumstances.[995] He was rotated between two cells with another resident so that neither would go for more than 24 hours without a window. He states that "*it was insane to treat children like that … No one should be placed in 24-hour solitary confinement as a child, no matter what they have done".*[996]

4.788 WN73 spoke of his loneliness and his slide towards depression as a result of being kept in isolation.[997]

4.789 The longest single period WN73 spent on Status 1 remand was two months and the longest period in solitary confinement was one week.

4.790 A number of other witnesses allege that during this period they were placed in secure accommodation for prolonged periods lasting months at a time.[998]

4.791 Kevin Mansell told the Inquiry that he questioned whether it was appropriate to remand young people with such frequency and for such long periods of time. He was concerned at the possibility of a breach of their human rights and raised the issue with the Director of Education, Tom McKeon.

4.792 Tom McKeon recalled a meeting with Magistrate Ian Le Marquand to discuss the Courts' approach in an effort to resolve the issue.[999] Ian Le Marquand had written to the Director of Education concerned that the Governors could not reassure him that young people could be placed in a custodial environment at Les Chênes: *"I do not think that the general public will be at all happy to learn that the Courts do not have any secure post sentencing custodial facility for young people under the age of 15 who repeatedly re-offend with serious offences because the only facility which existed has been withdrawn by the Education Committee".*[1000]

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[995] WS000443/10
[996] WS000443/13
[997] Day 56/70–71
[998] WN627: WS000447/3; WN630: WS000450/4; WN698: WS000511/7; WN628: WS000448/2
[999] Day 77/108
[1000] WD003955

4.793 Tom McKeon's assessment to the Inquiry (in his role as Director of Education) was that:

> " … *the problems that were being confronted by the school at that time were not just a reflection of what was happening in the community, because there was a spate of offending by young people, but were also a reflection of the requirements that were being laid upon the school by the Court. The Court was adopting an increasingly inflexible approach to the way in which the children could be provided for and it added to the pressure that the school was facing, hence my meeting with Ian Le Marquand to try to resolve the issue*".[1001]

4.794 Tom McKeon agreed in evidence with the suggestion that Ian Le Marquand appeared to take a punitive approach toward the children at Les Chênes.[1002]

Staffing issues

4.795 Peter Waggott told the Inquiry that from 2000 onwards he was aware that the Principal had made a number of approaches to the Education Department for additional funding to employ more staff or to completely change the staffing model with care staff and teaching staff as separate bodies. He said that the Department was not interested at that point.[1003]

4.796 Tom McKeon thought Peter Waggott's conclusion was "*very unfair*" and reflected a "*high degree of frustration and concern because (the staff) were not able to provide appropriately for the young people in this very challenging situation*", adding, "*I'm in no way critical of the staff at Les Chênes … at any time and of the work they were trying to undertake. I do believe that as the pressures grew the provision proved to be entirely inadequate"*[1004] He told the Inquiry that he did view the predicament at Les Chênes at the time as a pressing concern: *"in the sense that I would not want any part of our service to feel inadequately resourced but the source of challenge was beyond our control … the level of challenge was becoming something that the place could no longer deal with".*[1005]

[1001] Day 77/108
[1002] Day 77/124
[1003] Day 75/158
[1004] Day 77/100
[1005] Day 77/105

4.797 In July 2002, Tom McKeon wrote to Anton Skinner (Acting Chief Executive, Health and Social Services Department) stating that the Education Committee had determined that henceforth Les Chênes was to be used "*exclusively for the purposes of secure remand*" in line with the Bull recommendations. He added that it was the Committee's belief that the *"school ethos and training, experience and skill set of the current staff are ill suited to the changed circumstances".*[1006]

4.798 In Kevin Mansell's view Les Chênes was "*left to struggle*"; the budget was insufficient to deliver the services the school was expected to deliver.[1007] He was asked to respond to the view expressed by the Chair of the Governing Board (Mr McLean) that from 1997 "*it became clear that the organisation of Les Chênes was falling apart".* Kevin Mansell in turn considered this unfair. The staff were dedicated and doing their best for the young people, but were not receiving support (mainly financial) to develop resources at the school.[1008]

4.799 Kevin Mansell said in evidence that he did not think that Tom McKeon was aware of how difficult things were at Les Chênes in this period.[1009]

4.800 Jonathan Chinn felt that the teaching staff were not well equipped to deal with this new intake (later he put this down to the number of students coming in rather than the nature of the intake *per se*):

> "*A lot of the earlier days I think it was good old fashioned delinquent children. When it started coming into drugs – and you're talking serious drugs here, heroin, etc, and everything else that goes along with that – and self-harm – some students started to self-harm and that was something that I did feel uncomfortable about because that was a sort of different spectre, or different from what we had been used to dealing with before and I did not think I was quite trained up to be a psychiatric nurse, which I sometimes said that, we really need a psychiatric nurse, but obviously with the finances and the number of students we had in there it would not have been worth that sort of expenditure, but I know the school as quickly as it could be used to get the Ed Psych in and everyone to try and get some support or help".*[1010]

[1006] WD007368
[1007] Day 80/159
[1008] Day 80/70
[1009] Day 80/78
[1010] Day 71/72

4.801 Jonathan Chinn also remembered that by 2002 the school was containing children on remand "*in the ordinary bedrooms*". He agreed that by this stage there were some students who were being kept in Les Chênes in a way that the Court had not envisaged. It was he says through no fault of the school or the staff, "*it became difficult for staff to work there and obviously the students were becoming huge problems with the drugs, there were children absconding and I think that put more pressure on the school because the Courts were unhappy that the children were absconding*". He believes that staff would have had the expertise to manage some of the intake "*if there had not been so many of them*".[1011]

4.802 Peter Waggott told the Inquiry that in this period he and his colleagues had been taken by surprise by "*a sudden influx of a cohort of young people who had committed lots of offences together outside of school*".[1012]

Running Les Chênes after the Bull Report 2001

4.803 Jonathan Chinn told the Inquiry that when Dr Kathie Bull's 27-page 2001 Report[1013] was published, Kevin Mansell was keen to bring about the changes recommended.[1014] One recommendation was that those on remand be placed back in a mainstream school. Running Les Chênes after the report came out was "*extremely difficult because we were understaffed".* Kevin Mansell said that significant input was needed to enable the transition but no additional funding was provided.[1015] The recommendations he did implement included individual care plans, education plans and risk assessments.

4.804 Having reviewed a raft of management and other issues,[1016] the report was widely critical on a number of fronts. The report identified the pressures placed on the school:

[1011] Day 71/89

[1012] Day 75/165

[1013] "*Review of the Principle, Procedures and Practices at Les Chênes Residential School*"; the report was commissioned by the Director of Education after a specific incident of violence towards a member of staff at Les Chênes

[1014] Day 80/68

[1015] Day 80/68

[1016] Admissions, assessment, court procedures that impact on the school's role and function, use of the secure unit, behaviour management and the use of physical force, staffing and staff training, premises and accommodation and proposed redevelopment

> "*The number and type of young person admitted to Les Chênes have changed markedly over a period of at least three years but certainly over the last eighteen months. It would be usual for a special school to have admission's procedures which allow each pupil to have a settling in period before another pupil is admitted. This so as not to destabilise the existing cohorts. However, such a routine is not possible. Pressures on the Court as a result of a rise in the number of young people appearing before it and the changing profile of youth crime is having a serious and detrimental knock-on effect upon the school. Indeed, at points throughout the year the school has had to admit: (a) more pupils in total than it has space to accommodate (b) more pupils on custodial remand than it has secure beds to accommodate (c) an excess of pupils for which the staffing ratios are inadequate".*

4.805 It called into question whether Les Chênes as an educational establishment could meet the needs of those on secure remand, those on welfare placements and those "*who are vulnerable and may require a place of safety*". The Report queried whether this provision should be within the remit of the Education Department.

4.806 In respect of the use of the secure suite "f*or all young people on entry to Les Chênes"* the Report concluded that this was "*most unacceptable*" and that the fabric and configuration of the secure unit was "*not fit for purpose*". The MAS (revised in 1996) was seen to be of limited use. The home leave element of the system was a "major weakness" – "*leave should be a right for any child in a residential school".* The absence of behaviour plans was "*not wholly defensible".* The report expressed concern about the absence of training in the use of restraint. A policy for the use of reasonable force was needed "*across major departments*".

4.807 The Report found that *"the absence of qualified and experienced childcare professionals is not acceptabl*e" and reliance on supply cover for staff *"an overwhelming weakness of the organisatio*n"…. "*Without a radical overhaul and review it is possible that the current weaknesses will be perpetuated, with little gained overall for the young people. The present arrangement whereby the head teacher and the deputy share, over a 36 day period, the management of the school, 24 hours daily, is clearly unsustainable".*

4.808 Other recommendations included agreeing with the Magistrate "*a set of procedures for the admission and detainment of young people*" reflecting

concern for the "*very serious weaknesses*" at Les Chênes and "*the extreme constraints*" on accommodation. A policy for the use of reasonable force was needed "*across major departments*".

August 2003: police called to Les Chênes

4.809 In mid-August 2003,[1017] the police were called to Les Chênes following an incident involving two residents. Derek Carter was on duty and called for the police to attend; he also telephoned Peter Waggott (Acting Principal) who arrived at about 9.30pm. Derek Carter gave detailed evidence to the Inquiry about the episode.[1018]

4.810 Peter Waggott described the two young people involved as *"habitual offenders … hell bent on creating trouble*". The police used CS spray. Peter Waggott said that, had he been asked at the time, he would not have sanctioned its use.[1019]

4.811 Peter Waggott felt unsupported over the incident and his impression was that the Director, Tom McKeon, held him responsible as Acting Principal for what had happened. He told the Inquiry:

> *"We had requested that staffing was improved and the building was improved and repeatedly that had been knocked back and our perception was that [Tom McKeon] because he had established the school thirty years earlier on a particular model … that model was okay and if we were not managing on that model it was us that was at fault".*[1020]

4.812 A member of the care staff (2002–2003) gave an account to the police of the build up to the incident. She believed that two of the residents "*kicked off*" and a member of staff locked them both in a glass room next to the day room and the secure area. The room contained computers and other expensive electrical devices. Police photos received in evidence show extensive damage;[1021] the armed response Police were called and the building evacuated. She felt that locking the boys inside the glass room was

[1017] See WD006416/

[1018] Day 96/151

[1019] Day 75/185

[1020] Day 75/174

[1021] The Inquiry received in evidence a folio of police photographs of the scene following the incident: WD007341

"*inappropriate in the circumstances*".[1022] At the time she did not hear the commotion as she was in the secure area "*minding a young female*".

The Madeleine Davies Report[1023]

4.813 In 2003, two residents at Les Chênes disclosed that WN708, a staff member, had supplied them with drugs. The police were informed and WN708 was suspended with immediate effect. There were also concerns that he had acted inappropriately with female residents.[1024] He subsequently pleaded guilty to possession of drugs. This episode may have prompted the commissioning of a report from Madeleine Davies, Head of Staff Services published in 2003.[1025]

4.814 Madeleine Davies carried out an unannounced inspection of Les Chênes in August 2003 at the request of the Director of Education (Tom McKeon). It addressed the following issues:

4.814.1 keys to the secure area;

4.814.2 checks on the secure cells;

4.814.3 observations on the day rooms, classrooms and offices;

4.814.4 recording procedures;

4.814.5 young persons' interviews;

4.814.6 staff induction and training;

4.814.7 records on absconding, and

4.814.8 procedures on administration.

4.815 An extract from the report highlighted "*some inappropriate and legally dubious methods of managing pupils because both the Court and the Committee have endorsed the caveat 'as deemed appropriate by the Principal' without the*

[1022] WD006144
[1023] WD004276
[1024] WD006182/93
[1025] WD004276

necessary training and guidance being given to both teaching and non-teaching staff. The management of young people's behaviour is through a points system. Staff are not consistent in the awarding or removal of points".

4.816 Peter Waggott accepted in evidence that the report was damning. When asked for how long he had felt that the staff at Les Chênes had been too stretched, he said: "*I honestly think that for most of the time when I was Deputy Principal we were stretched. I would say that the Principal and I were working 70, 80, sometimes 90 hours a week trying to cover shifts that could not be covered in any other way*".[1026]

<u>Residents' perspectives</u>

Culture

4.817 WN13 was admitted to Les Chênes in around 1980 and spent approximately two and half years at the Home. He states that *"it was much better than Haut de la Garenne and although it was strict, the regime was better with good educational programmes in place".*[1027]

4.818 WN625 was resident at Les Chênes between 1984 and 1986. He gives a positive account when it came to discipline at the Home, stating that the cane was used rarely and generally *"there were words but no violence".*[1028] The only violence he witnessed at Les Chênes was directed towards staff by residents.[1029] WN625 adds that *"during the entire time I was at Les Chênes I did not see anything wrong. It was a great school and the system worked perfectly. My memories are all good ones, and always will be".*[1030]

4.819 By contrast, WN311, who was admitted to Les Chênes in 1981, states that *"Les Chênes was worse than Haut de la Garenne as you would get locked up in your rooms and there was a points system in place where you would get*

[1026] Day 75/178
[1027] WS000354/4
[1028] WS000441/3
[1029] WS000441/3
[1030] WS000441/4

rewarded for doing certain chores and would have points deducted for not doing what you were told".[1031]

4.820 William Dubois, who resided at Les Chênes for temporary periods while on breaks from his boarding school during the late 1980s, describes his first impressions of Les Chênes as being worse than that of other children's homes *"because it was like a prison for children and the staff there were worse than they were at any other children's home".*[1032]

4.821 WN73 states that he was admitted to the Home at various points between 2002 and 2005, under a care order. In his evidence to the Inquiry, he stated that the Home was run more like a borstal than any sort of rehabilitation centre.[1033] He describes the mix of children who were resident at the home at that time, and explains the effect this had on his own behaviour: "*It was very easy to fall in with a bad crowd when you are in such places because you are forced to mix with children that have committed offences and there was not a lot of contact with other friends from home and school. I became friends with the other young people in Les Chênes who were stuck in an endless cycle of reoffending, being remanded in custody and being released".*[1034] WN73 also recalls there being regular *"kick offs"* and even riots at Les Chênes when rooms were damaged by residents and the police were called.[1035] He also describes residents using illegal drugs while admitted to Les Chênes and states that these were supplied by a member of staff at the home, WN708.[1036] WN73 reflects that *"these incidents show that not only had I been put, by the police and the Children's Service, in an environment where I was mixing with a bad crowd of children, but the staff were also helping me and other residents to get drugs".*[1037]

[1031] WD003499/4
[1032] Day 62/35
[1033] Day 56/96
[1034] WS000443/9
[1035] WS000443/14
[1036] WS000443/15
[1037] WS000443/16

Daily routine

4.822 Edward Walton was a resident at Les Chênes between 1979 and 1982. In his witness statement he gave a detailed description of the routine at Les Chênes:

> "*The routine at Les Chênes was the same every day. The children would wake up at 7am. We would have a wash, get our clothes on and make sure our beds were immaculately made. We would then go down* for *breakfast … After breakfast some of the children cleaned up the breakfast pots, whilst others went to carry out morning chores and clean their rooms. After this, staff would come and inspect our work and, depending on how well we had done, award points on our orange points cards. After breakfast and inspection, there was assembly … At the end of assembly WN108 would usually see those children that were due to be punished. …. After assembly we went to class … followed by lunch … Dinner was then served at around 4.30pm. We often played sport in the afternoons. This usually consisted of a game of football in the field next to the buildings. As there were only eight children there WN108 and one of the other teachers would usually join in".*[1038]…"*The routine was relaxed a little bit at weekends. At weekends we were allowed to get up later. We all mucked in to cook a fry-up breakfast. We would often do activities, and I remember on many occasions being taken in a minibus to the beach when the weather was fine. Given that the weekend timetable was less rigid, this was a good time to get points on your card. I glazed the greenhouse for four points per pane and would mow all the lawns in the grounds for around 150 points."*[1039]

4.823 A *similar* description of the daily routine was given by WN625, who was resident at the Home between 1984 and 1986: "*On a normal day you got up at 7.30, went for breakfast and after that there was a rota system where you had to do some cleaning in an area for half an hour. Then you went to assembly conducted by WN108 in the day room and after that everyone would go about their school lessons … You would have your lunch at normal time, and dinner which was at about 5pm".*[1040]

[1038] WS000492/13

[1039] WS000492/14

[1040] WS000441/2

Staff and the MAS

4.824 Edward Walton describes WN108 as being "*firm but fair*"[1041] and recalls having a positive relationship with Mario Lundy.[1042] He describes the points system in positive terms, stating that it was effective and that its connection with home leave was not intended to punish residents but to provide them with an incentive.[1043] He told the Inquiry, "*I had a bad experience in La Preference … Les Chênes … was a better environment and I think it was definitely more nurturing than the home environment*".[1044] He remembers WN108 would be required to physically intervene on occasions to prevent children from fighting.[1045]

4.825 WN387, who was admitted to Les Chênes in around 1986, provides a similar description of WN108 and of Mario Lundy as *"strict but fair".*[1046]

4.826 WN625 also gives a positive account of staff at Les Chênes, stating that *"all the teachers at Les Chênes, they were all brilliant, very committed, right on top of their game. They needed to be to make that school work".*[1047] WN626, who was at Les Chênes from around 1984 to 1986, describes the staff as being *"approachable"* and *"reasonable".*[1048]

4.827 WN624 recalls that, every week, WN108 would sit down with children one on one to discuss their points. She is one of a number of witnesses who recalls different members of staff approaching and applying the system in different ways. While some were more generous with points she states that others, like WN246, used to take away points for no reason.[1049] She is also one of a number of witnesses who refers to the *"600 club",* which referred to children who had enough points to go home every weekend, and suggests that this

[1041] WS000492/14
[1042] WS000492/116
[1043] Day 62/36
[1044] 62/68/11
[1045] WS000492/14
[1046] WS000366/2
[1047] WS000441/4
[1048] WS000442/2
[1049] WS000509/8

was for the *"extra smart children".*[1050] WN624 describes the inconsistencies in treatment in the following way: "*Points seemed to be another way of getting us to retaliate and compete against each other. Certain children who were the teachers' favourites always seemed to get more points than others. The staff were certainly not fair in the way they awarded points. I often found that I was good through the whole of a lesson, but would only be given five points. Someone else might have been a pain but still be given nine points. It felt as if points were being taken off because my face did not fit. All in all the points system was not a fun way to live life*".[1051]

4.828 WN311 also gives a negative account of the points system that was in place, suggesting that it was open to abuse by staff. She states that *"points would be deducted by the staff for poor behaviour but often they would take points off you for nothing and some enjoyed telling you that you could not go home".*[1052]

4.829 Two witnesses, WN623 and WN673 gave accounts of staff deliberately docking points from residents[1053] or preventing them from obtaining points,[1054] with WN623 stating that staff would do this when they knew they had plans at weekends.[1055] The allegedly arbitrary and inconsistent application of the points system was a source of complaint for many witnesses.

4.830 The connection between points and home leave is criticised by other former residents of Les Chênes, including WN215, who describes the *"mental torture"* he suffered due to the points system, which meant that he could not visit home at weekends.[1056] WN624 describes how residents *"were scared of doing anything wrong, as it meant that you could not go home for the weekend".*[1057] WN630, a resident at Les Chênes between 2001 and 2004,[1058] gave a negative account of this system, stating that "*it was very hard to get the points and very much easier to lose points. You had to earn 500 points*

[1050] WS000509/8
[1051] WS000509/9
[1052] WD003500/2
[1053] WS000508/4
[1054] WS000498/4
[1055] WS000508/4
[1056] WD003114/10
[1057] WD003500/4
[1058] Les Chênes was re-designated Greenfields in September 2003

just to get your trainers back. You lost points for swearing, inappropriate behaviour like throwing food around and 'play fighting'. Most of my weekends were spent in the day room".[1059]

The use of the secure suite and secure cells

4.831 WN621 was admitted to Les Chênes in around 1984. She provides a description of the secure cells at the Home: "*It was basically an empty room with just a mattress in it which was in the corner on the floor. You were not allowed possessions in there with you. If you needed the toilet there was a bell you rang to get someone's attention. You had to sleep in there and the night staff would watch you. The doors were solid wood doors with glass panels to see in at you. There was a light but it was accessed and controlled from the outside by staff".*[1060]

4.832 Many *witnesses* recall being placed in the secure cells when they first arrived at Les Chênes, including WN627,[1061] WN629,[1062] WN651,[1063] WN145,[1064] WN673[1065] and WN153:[1066] they say they found this a frightening introduction to life at Les Chênes. There are varying accounts as to how long this initial placement in secure accommodation would last. WN625 states that it would only be used for the first night of admission,[1067] whereas WN622 states that he spent around two weeks in the secure cells and was locked in at night but would be allowed out during the day.[1068] William Dubois describes being kept in the secure unit in the temporary periods he spent at Les Chênes when he returned from boarding school, and not being allowed to participate in activities with other young people who were resident at the Home.[1069]

[1059] WS000450/3
[1060] WS000438/2
[1061] WS000447/2
[1062] WS000449/2
[1063] WS000478/2
[1064] WS000485/2
[1065] WS000498/3
[1066] WS000675/9
[1067] WS000441/3
[1068] WS000439/6; WN387 also states that the initial period was a couple of weeks (WS000366/2)
[1069] Day 62/55

4.833 In respect of his initial placement in secure, WN651 states that *"the purpose of my first two weeks was so that I would acclimatise but it just left me feeling scared and isolated. I had come from a family home into a locked cell and basically cried myself to sleep every night. I thought it was well out of order to treat a young lad in that way in his first two weeks of detention".*[1070]

4.834 As well as the secure cells being used on admission, varying accounts are given in relation to whether and to what extent the secure accommodation was used as punishment for residents at Les Chênes. WN625 states that secure cells were only used on the first night that children were admitted to Les Chênes but were never used as a punishment in the time that he was resident at the Home, between 1984 and 1986.[1071]

4.835 By contrast, WN622 recalls around 10 occasions on which he claims he was placed in secure accommodation for half a day at a time as punishment for misbehaviour.[1072] Similarly, WN621 claims that she was placed in the secure unit once for swearing at WN112.[1073] Other witnesses who allege that they were placed in the secure cells as punishment include WN250, for absconding from the Home with a friend[1074] and William Dubois for failing to wash dishes quickly enough.[1075]

4.836 Some residents, such as WN624, state that they were never placed in the cells at Les Chênes, not even on arrival, though she recalls that sometimes other children would be locked in the cells for a couple of weeks, and would only be allowed one hour of exercise outside the cell per day.[1076]

4.837 The evidence from residents in relation to Les Chênes in the early 2000s is of a different character from the earlier period. During this time, a number of residents make allegations of more prolonged admissions to the secure unit at the Home. WN73 provides a description of the secure accommodation during

[1070] WS000478/2
[1071] WS000441/3
[1072] WS000439/6
[1073] WS000438/3
[1074] WS000081/4
[1075] WS000299/10
[1076] WS000509/5

this period in similar terms to WN621 above, though he explains that a frame for the bed and a table and chair were later added to the rooms.[1077] He and another witness state that at this time new admissions were strip-searched and placed in a cell for 24 hours when they first arrived.[1078] Reference has already been made to WN73's account of being kept in secure.

4.838 A number of other witnesses allege that they were placed in secure accommodation for prolonged periods, lasting months at a time. WN627 was admitted to Les Chênes in around 2000 and states that following an attempt to escape he was placed in secure for a period of one to two months.[1079] WN698 was also admitted in around 2000 and recalls being placed in the secure cells for prolonged periods, commenting that she found it *"unbelievable that children of my age could be locked away like that for such long periods".*[1080] WN630 recalls that he frequently spent time in the secure unit. He states that residents would be placed in secure accommodation for refusing to do something when asked by a member or staff or for fighting, and they could be placed there for three or four days.[1081] WN630 further alleges that, in 2004, he was kept in the secure unit for a period of nine months, during which time he was given lessons in the vestibule area.[1082] WN628 was admitted to Les Chênes on remand in 2003, and alleges that he was taken to the secure unit on arrival and spent the duration of his two-month admission in isolation, save for one hour per day.[1083]

Governance (ii)

4.839 Les Chênes was governed by a combination of an Advisory Board (later known as the Board of Governors) and by the Education Committee during the relevant period. The input of these bodies into the management and organisation of the School is addressed under the heading of each Principal above. Furthermore, the specific question of the oversight provided by the

[1077] WS000443/8
[1078] WS000443/4; this process is also described by WN620, WS000450/2
[1079] WS000447/3
[1080] WS000511/7
[1081] WS000450/4
[1082] WS000450/5
[1083] WS000448/2

Board of Governors is addressed in detail in Chapter 5, in which we consider the evidence that Ron McLean provided to the Inquiry.

Findings: Les Chênes: under Tom McKeon

4.840 When Les Chênes first admitted children in 1978, Tom McKeon described the facility as "*an approved school and remand centre for young offenders and juveniles who were out of control*". In our view by 1978 this was no longer a viable model of education; we note that, in 1971, Approved Schools had been abolished in England to be replaced by Community Schools with Education. Although we are mindful of the scale of Jersey and the consequent small intake at Les Chênes we question whether from its inception it was predicated on a flawed model in combining an Approved School ethos with a remand centre.

4.841 We are mindful of John Pillings' assessment of Les Chênes in 1980, in which he suggested that the management of Les Chênes placed emphasis on the efficiency of group control and like HDLG "*could be in existence more to meet staff needs than children's needs*". We note the evidence from the 1978 handbook and from Monique Webb and Jonathan Chinn on the highly structured timetable. Set against that is the assessment by Lambert and Wilkinson, in 1981, that Les Chênes appeared to the Inspectors to have been providing a unique experience for the resident children, based on what appeared to be a high quality of specialised education and one they described as "*a very warm and committed approach to the children by the adults*". The report identified a "*security and sense of purpose*" and professionalism.

4.842 We take note of Tom McKeon's acceptance of the validity of Dr Kathie Bull's view that, in 2001, denying home visits was very unacceptable practice. While Tom McKeon thought this applied to the group of children in 2001, we find that it applied equally to the intake while he was Principal in the late 1970s and 1980s. We see no justification for this practice in whatever period of Les Chênes' existence.

4.843 We note the apparent conflict in evidence between Tom McKeon, who maintained that only those on remand were placed in the secure suite on

arrival, set against that of his own statement describing CCOs dropping welfare placements off to the secure unit, his 1983 paper ("*when children first arrive at the school or indeed on placement via other means they are normally placed in secure*") and the evidence of WN651, which suggested that welfare placements were also placed in secure. We find that welfare placements were placed in secure as a matter of routine when they first came to Les Chênes during Tom McKeon's tenure. We find that this was wrong and an inadequate means of management. Although we do not recognise the validity of Tom McKeon's distinction between a child with psychological problems and those with "*an offending nature*", even on Tom McKeon's own account, he recognised that placing a child with psychological problems in secure was unacceptable. Even on the two or three occasions as suggested by Tom McKeon, that the secure unit was used under his tenure as a means of punishment, we again find that this was wrong and a less than adequate approach.

4.844 While we recognise that there would have been little external guidance or training available at the time on restraint, given what we find to be the prescriptive and heavily structured regime at Les Chênes at this time, we question the absence of any internal guidance for staff on the use of physical force. We find that this absence will have given rise to inconsistent and at times excessive use of force by adults on children. We consider this to have been an inadequate aspect of the management of Les Chênes at the time.

4.845 We conclude that under Tom McKeon, Les Chênes was managed in a strict and physically dominant way by the Principal and Deputy, Mario Lundy. We also note the number of allegations of physical abuse that relate to this period. The culture and ethos of Les Chênes was closer to what was by then the outdated model of an Approved School.

Findings: Les Chênes: under Mario Lundy

4.846 On the evidence that we heard, including that of Mario Lundy himself, we consider that the culture of Les Chênes was entirely determined by the personality and presence of Mario Lundy: his was a physical and robust

approach informed by his own vision of how the school should function and what its goals should be.

4.847 Both staff and resident witnesses describe the quality of teaching during this period and Mario Lundy's drive and involvement. We think in this respect that the educational provision for those placed at Les Chênes was adequate during Mario Lundy's tenure, and that this reflects positively on his management of the school.

4.848 There is contrasting evidence about the use made of the secure suite during Mario Lundy's period as Principal. Mario Lundy told the Inquiry that the use of the secure cells was "phased out". We question whether this was in fact the case, given that on our understanding the school was receiving remand placements throughout the decade, as Mario Lundy himself recognised. The 1990 Les Chênes School Handbook stated that secure cells were not to be used for "*time out*" isolation or containment, yet Mario Lundy acknowledged that the cells might still have been used for these purposes after 1990. We call into serious question the use of the secure cells in the early 2000s and specifically in relation to welfare placements (as described). We find that the secure cells probably were used for isolation and containment in the 1990s, bearing in mind Mario Lundy's qualified response on the issue.

Findings: Les Chênes: under WN109

4.849 We note the generally positive evidence on WN109's approach to the curriculum at the school in the three years he was Principal. We also note that there are no allegations made against WN109 in this period.

4.850 However, and as identified by Dr Kathie Bull and as we read in evidence, the problems of over-crowding, hot-bedding and mixing welfare and remand were already evident from 1997. We conclude that there was a failure of governance to address these issues sooner and notwithstanding that they were being identified by WN109 and brought to the Board of Governor's attention.

Findings: Les Chênes: under Kevin Mansell

4.851 Evidence from staff suggests a combination of factors coinciding at this particular time:

4.851.1 a particular group of challenging young people being placed in the school;

4.851.2 the approach adopted by the Court in ordering remand placements;

4.851.3 the apparent sudden influx of increased population in the school;

4.851.4 the adequacy of training provided teaching staff in meeting the challenges presented by handling a large number of remand placements;

4.851.5 the role played by the Director of Education.

4.852 Evidence from staff working there at the time suggests that over this period they were reacting to what was happening rather than being able to manage the school. We find this to have been the case.

4.853 We find that the management of Les Chênes under Kevin Mansell fell substantially below an adequate standard. We attribute the failure in management in large part to circumstances beyond the control of Kevin Mansell and his staff, although their response to the pressures they were under also falls to be criticised. Notwithstanding the assault and threats to which he and his family were exposed in 2001, and the enormous pressure that he and his staff were under, we find that Kevin Mansell failed to manage his own staff. This was a pressure to which they should not have succumbed, regardless of the lack of support that they should been given by the Education Committee and Director of Education. This pressure resulted in poor decision making – for instance, keeping children in secure while having staff meetings – as well as to over-reaction in the use of restraint and what we find to have been the indiscriminate use of the secure suite.

4.854 We find that Kevin Mansell and his staff were poorly supported by the Director of Education, Tom McKeon, who appears to have distanced himself from Les

Chênes in this period. We find that his evidence to the Inquiry about this period reflected his view that Les Chênes had lost its purpose and way. We conclude that the Education Department failed to give adequate support to Les Chênes and allowed it to flounder.

4.855 We consider the comprehensive failings identified by Dr Kathie Bull relating to all aspects of the running and management of Les Chênes are failings that should have been identified earlier. We conclude that the Director of Education, the Education Committee and the Board of Governors at Les Chênes failed to exercise proper oversight and governance during this period. While it might be argued that those responsible for Les Chênes could not control decisions of the Magistrate's Court it is difficult to justify the fact that they expressly concurred in a plan to mix remand prisoners and children in care in the same school. The resulting gradual transformation of the school into a remand centre was entirely foreseeable, as was the potential damage to those children not on remand. The result was that those responsible for the care of children effectively surrendered control.

4.856 We view the attitude and approach of Magistrate Le Marquand as indicative of an attitude on the island at the time encapsulated in the Chair of the Board of Governor's Ron McClean's view that Les Chênes was full of *"little villains"*. We are under no illusion as to the management issues posed by individual young people placed on remand at Les Chênes at this juncture, but we consider that there was a failure of agencies – the school, the Director of Education, the Probation Service, Children's Services and the Courts – to work together constructively and decisively. The result was disastrous for staff and residents at Les Chênes alike. The experience of WN72 is an example of the consequences of this failure: his repeated detention in the secure suite over a long period was a serious failure of management.

4.857 The ethos was one of containment and control rather than any therapeutic focus. Throughout its existence, Les Chênes was a harsh and inappropriate regime.

4.858 The initial decision to have Les Chênes staffed entirely by teachers was we find controversial. The 2001 Bull Report called into question the deployment

of an all-teacher regime. We find that this issue should have been addressed far sooner by those overseeing the management of Les Chênes.

4.859 The August 2003 "riot" incident at Les Chênes was in fact a relatively minor incident of disorder that, as a result of poor handling by staff, escalated out of all proportion. Once it had, the shift leader should have called the Acting Principal, Peter Waggott, before he called the police. The situation was not helped by the presence of the police rapid response team.

Greenfields

Management and organisation

4.860 In around September 2003, what had been called Les Chênes was re-named the Greenfields Centre.[1084] Greenfields was to be run by a "Children's Executive"[1085] and a team of care staff was to work alongside teaching staff. By October 2003 Greenfields' first "Centre Manager" WN687 had resigned; in the interim Greenfields was run by Wendy Hurford and Danny Wherry from "Social Services" before Joe Kennedy took up his appointment in November 2003.

Joe Kennedy (2003–2006)

4.861 Prior to 2003, Joe Kennedy had spent 24 years working in the Jersey Prison Service. From 1979 to 1991, he had been a Prison Officer based at La Moye. He then went on to be responsible for training and development of prison officers. He also ran the Young Offenders Institute (YOI) at La Moye, the island's prison: this had included managing the introduction of a new regime in the YOI. It was, he told the Inquiry, "*a radical departure*" from the way that it had been run before. He ran it from 1994 to 2003. He told the Inquiry that throughout his time at the YOI he had been unaware of Les Chênes. He had not known that 60% of those who had left Les Chênes had gone to La Moye,

[1084] WD006312/7

[1085] WD006312/7: although this is the phrase used in the minutes, it is not clear whether this is correct

nor did he realise that, in 2000, consideration had been given to deploying prison officers at Les Chênes.[1086]

4.862 The Greenfields' Governing Body minutes for October 2003 record that Mike Kirby, Prison Governor, had agreed to release Joe Kennedy on a short-term basis until mid-January 2004. The same minutes recorded that: "*The Director [of Education] acknowledged that he had become increasingly aware that retaining Greenfields as a school was not sustainable. It was clearly no longer an educational establishment but a remand centre. The children were very disturbed with numerous behaviour problems. Education would continue to be provided within the confines of the Centre".*[1087]

4.863 In his evidence to the Inquiry, Joe Kennedy contrasted the admissions process to the YOI and to Les Chênes, describing the approach that he had adopted as the "my kid" approach: what would it take for that child to feel safe?[1088] He challenged the suggestion the children were placed in solitary confinement or isolation at Greenfields, " … *where you have aberrant behaviour that threatens the stability or whatever of the environment you're in with a child or with a prisoner, it's often practical to remove them to allow those that are adversely affected by that behaviour not to experience it anymore and for the person who is causing that behaviour the opportunity to realise that (a) it is not tolerated and (b) that they can reflect on that*.[1089]

4.864 He explained the difference between what he termed "*dynamic security*" and "*physical security*". He told the Inquiry that when he started at Greenfields the staff's standards on security were "*evolutionary*". In his view, the care staff felt that they had to "*hold things secure … A reliance on the physical security of the building"* and on their ability to control the young people who lived on site.[1090]

4.865 In response to questions he confirmed that in both the old Greenfields (formerly Les Chênes) and in the new Greenfields Centre buildings (opened in

[1086] Day 72/77
[1087] WD006312/7
[1088] WS000581/4
[1089] Day 72/80
[1090] Day 72/84

2006), bedroom doors could be locked from the outside and the water and electricity supply to the rooms was controlled externally. He took the Inquiry through the plan of the new Greenfields Centre.[1091] When the new building was being constructed Joe Kennedy recalled that he arranged for the viewing windows on doors to bedrooms and the cells to be removed, *"I found the viewing windows unsettling to think that someone walking past a child's bedroom could look in*". He did not agree with the suggestion that the desired approach for the new Greenfields Centre was more informed by prison design than residential design,[1092] but accepted that having bedrooms at Greenfields which were a variation on a prison cell was not an appropriate way to deal with disturbed young people. Extracts from minutes of a Board of Governors meeting in 2005 recorded Joe Kennedy presenting site proposals for the new Greenfields. He told the Inquiry that he had visited "*a number of facilities in the UK*" although these had not included prisons or YOIs. In relation to rooms he said *"some rooms would be suitable for isolation or upgrading as part of an incentive scheme. All rooms would look inwards*".[1093]

4.866 Jonathan Chinn felt that Joe Kennedy made the school safe for both the staff and children, "*he seemed to get it organised. The staff seemed to have respect for him, the students seemed to have respect, it was still a difficult place … but things seemed to work a lot better".*[1094]

4.867 Kevin Mansell felt that although Joe Kennedy had a prison background he had had the best interests of the young people at heart. He remembered that under Joe Kennedy, the teaching staff were not able to place children in secure.[1095]

4.868 One member of the care staff (November 2003–2009 and employed at time of statement to police) remembers that a month after he had started at Greenfields, Joe Kennedy "*changed the cells and accommodation in each*

[1091] WD006312/66

[1092] Joe Kennedy provided plans of the new Greenfields: WD006312/67

[1093] WD006172

[1094] Day 71/100

[1095] Day 80/98

room by building a fixed bed and a small table/workspace".[1096] Another member of care staff who started work in October 2003 remembers there being "*utter chaos until Joe Kennedy arrived [in November 2003] the young people had gained control of the unit. We had a lot of difficulties, they brought in four staff from the UK, they worked for an agency that provided police transport*".[1097]

4.869 WN73 was resident at the home from 2002 to 2005 and recalls that following the transition from Les Chênes to Greenfields, there was an increase in the incidence of staff restraining young people at the Home and states that, in general, the Home became a lot stricter.[1098] He states that *"it became clear that they were going to restrain young people despite there being no real need, as it was my understanding that to be restrained you had to be putting yourself or others at risk. The care staff were using it in such a way to begin with that you lost free speech".*[1099]

4.870 A similar account of the use of restraint is given by WN630, who was resident at Les Chênes from 2001 to 2004. He states that when staff were trained in restraint following the transition to Greenfields in around 2004, the staff behaved in an inappropriate manner and *"they got really heavy in taking advantage of the situation because they could do what they liked, instead of interacting with you and trying to sort out your problems. There were people getting restrained all around you all day".*[1100]

The "Grand Prix" system

4.871 Joe Kennedy introduced the "Grand Prix" system as a means of managing behaviour. He told the Inquiry that the incentives and earned privileges system used in the YOI at La Moye prison was not the same system introduced at Greenfields although both drew on the model of Grand Prix racing. He thought the "Grand Prix" system had worked in the prison environment because "*it was a very clear system. It was actually an incentive*

[1096] WD006130
[1097] WD005847
[1098] WS000443/18
[1099] WS000443/18
[1100] WS000450/4

scheme". It was much easier to adopt a universal approach at Greenfields than it had been at the YOI.[1101]

4.872 The "Grand Prix" system[1102] subsequently attracted controversy as a means of management of the old Greenfields.[1103] Under that system being "*in the pits*" meant that a resident would be placed in the secure suite and not in a bedroom.[1104] When asked whether the cells were used as a form of punishment under his management, Joe Kennedy told the Inquiry:

> *"It is an interesting distinction. I'm sure they felt quite punitive to people, but that was not why they were there. The purpose of the rooms being removed and constructed in the way they were was to allow young people to be removed if they were presenting a threat from the other young people. It was also to demonstrate to the other young people that if a member of that particular community presented in such a way as to threaten them, then they would be safeguarded from that."*[1105]

4.873 Joe Kennedy was asked about an entry in the communication book from December 2006, which read:

> *"All staff – as from today room one will now be the new admissions room, where new admissions will be placed after full admission. They will remain in room one for twenty-four hours with good behaviour. Should any unwanted behaviour be shown then the twenty-four hours may be started from the start of compliant behaviour."*[1106]

4.874 He said that the entry misrepresented what happened: *"the actual practice … the young person will be taken out into the ball park … and often would spend the entire day out there with staff*". He said that the Inquiry could *"confidently*" reach the conclusion that *"the pits*" were never used to lock someone up for 24 hours.[1107] He reflected, *"I was not wedded to the Grand Prix system, but I believed then and I still believe now that in order to successfully manage an environment which contains young people of that profile that there needs to be a clear and understandable code of conduct. I think it needs to recognise*

[1101] Day 72/89
[1102] WD005763
[1103] See JEP article WD006168 and the Howard League Report
[1104] Day 72/89
[1105] Day 72/109
[1106] WD005769
[1107] Day 72/11

and promote positive behaviour and that's its purpose, but equally I think it's essential that people – young people in particular – recognise that anti-social behaviour is not acceptable and it is recognised as such by the people who are charged with looking after them".[1108]

4.875 One member of care staff (2003–2009] recalls that the "Grand Prix" system sounded harsher on paper but *"in reality it was a better system which the residents made no complaints about"* – in his account to the police he explained how it worked in practice:

> *"If a resident was displaying bad behaviour, they would be placed in a cell for 3 days until they calmed down and behaved accordingly. They did not spend the full 3 days in there alone as a member of staff would sit and have a meal with them, watch television with them and take them out into the ball court for an hour's exercise, maybe longer. This episode was called the Qualifier (Level 1). If they did not calm down when they were first placed into the cell, then the 3 days would not begin until they did behave, hence why a resident once stopped in there for 4 days. On their release, they would be on Grid (Level 2) for 7 days which allowed them to have a television in their room as well as a radio. After the 7 days, they would be on Track (level 3) which allowed them to have a play station along with their television and radio. They were allowed to go out whilst on Grid, including home visits at weekends. As they moved up a level, the residents were also allowed to go to bed at a later time".*[1109]

4.876 Joe Kennedy told the Inquiry that, by 2008, the Pits had been abandoned. They were abandoned because Joe Kennedy said that "*We were better informed*". The evidence on the use of isolation as part of the pits under the "Grand Prix" system is confused. Joe Kennedy said that by the time of the move to the new Greenfields Centre, site security was sufficient not to require use of isolation in the secure unit. As at December 2006 a young person would be separated in their room, not in a cell.[1110] He never explained what he meant by "*better informed*". Later in his evidence to the Inquiry, when discussing Simon Bellwood's tenure, Joe Kennedy said that once the new Greenfields building was occupied, the "Grand Prix" system was *"abandoned"*:

[1108] Day 72/126
[1109] WD006130
[1110] Day 72/113

> "… *the Grand Prix system as it existed in the Old Greenfields was sufficient and of its time. Having moved in the new building I had anticipated that Simon Bellwood would introduce a way of working that would be different from the old Grand Prix system … My hope was that any such system would not only promote pro-social behaviour but would also address aberrant or anti-social behaviour. My observations were that such aberrant or anti-social behaviour was not being addressed and that caused me great concern".*[1111]

4.877 In 2007, the Howard League for Penal Reform[1112] set out its findings on the "Grand Prix" system, based on the documentation that it had been sent by Senator Syvret, who had invited the League to prepare a report on its legality. It commented that most children would not *"grasp the system*" as the document was not written in a "*child friendly"* or clear manner. The Howard League concluded:

> "… *It also lends itself to a 'male' regime based on 'formula one' car racing and may make girl prisoners feel excluded. In light of the physical and oversight concerns raised above*, t*he regime appears predicated on a complex system using isolation and deprivation as a means of control. At its most punitive a child could remain in the 'pits' for an indefinite period deprived of light, writing equipment, association with peers and warmth or comfort for extended periods. In light of the prevalence of mental health problems amongst this group of children with a negative response to boundaries and control, the risk is high of such an outcome. In the absence of any 'check and balance' on the use of such control the risk of 'abuse' must be high".*

4.878 In an undated single-sided document that, from its context, appears to coincide with the Howard League's letter, Joe Kennedy, then Residential Services Manager, responded to a series of questions raised by the Howard League in relation to the secure suite in the "former" Greenfields.[1113] The response includes an assertion that: "*single separation was not used as a punishment. It was only used where a young person was a danger to self or others".*

4.879 A folio of policies and procedures headed "Greenfield Centre" covered the following issues: risk assessment; complaints; confidentiality; remand of school-aged children (11–16); staff training courses; visitors; violence and

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[1111] Day 72/123

[1112] The Howard League were provided with a copy of the system (WD006312/10–16 and set out their findings in a letter to Senator Stuart Syvret (WD006312/99)

[1113] WD005766

aggression in a residential setting; child protection and bullying. Other written policies included “Greenfield Centre: Physical Restraint"[1114] and “Greenfield Centre: Physical Restraint – Reporting Requirements”.[1115] Two pages related to an amended “Grand Prix” system in use at the Greenfields Centre.[1116]

4.880 Under “staff training and courses”, Greenfields would “*endeavour*” to give care staff TCI training within six months of joining, the aim was to give staff six training days a year and it was noted that staff “*will have regular supervision*”. When Joe Kennedy took on full-time management of Greenfields in early 2004, all the care staff received therapeutic crisis intervention (TCI) training.

Governance

4.881 When Les Chênes closed as a school and Greenfields Centre opened as a secure facility the Governing Body of Les Chênes was replaced in March 2000 by a Board of Visitors[1117] for Greenfields which met "*twice a year minimum with visits to the Centre on a monthly basis”.*[1118]

4.882 Guidelines were produced for individual visits by Board Members which stipulated “*at least twenty-four hours’ notice to be given to Greenfields*” and that requests for one-to-one meetings with a child “*MUST be rejected*”. If the Visitor wished to see *“Kevin Mansell or a member of staff or any child – this would need to be for specific reason*”. The Guidelines conclude: “*It is essential that visits are treated with the utmost confidentiality: what goes on at the campus must be kept in there. Resist any temptation to discuss any matters with others outside of the Board of Visitors*”.[1119] Examples of monthly visits were in evidence before the Inquiry.[1120]

[1114] WD005765
[1115] WD005764
[1116] WD005767/28–29
[1117] Modelled on the body used in the prison system
[1118] WD006312/61
[1119] WD006171
[1120] WD006169

4.883 In October 2009, the Board of Visitors resigned en masse. This followed a recommendation in the Williamson Report[1121] that the responsibilities of the Board should be extended to include Heathfield and La Preference.

Simon Bellwood (2006–2007)[1122]

Management and organisation

4.884 In 2006, Simon Bellwood was appointed to run the new Greenfields Centre. He had a background in social work, qualifying in 2000. He worked initially with a youth offending team. In 2004, he was appointed Operational Manager of a unit at Leverton Hall Secure Unit in Essex for children between the ages of 11 and 17.[1123] Following his appointment Simon Bellwood was suspended in early 2007 from the role and never returned. There then followed a protracted series of formal investigatory procedures and employment proceedings initiated by Simon Bellwood. The employment proceedings were settled.

4.885 Simon Bellwood told the Inquiry that the Leverton Secure Unit had had a damning inspection report following which a behavioural management system was introduced, which, he told the inquiry, he was later to replicate at the new Greenfields site, or at least "75/80 per cent" of it. Leverton formed part of the UK's secure accommodation network. Simon Bellwood had found little to criticise about the system and approach at Leverton, which had also been subject to unannounced inspections.[1124] Solitary confinement at Leverton would take place in the young person's bedroom – it was called "single separation". The door to the bedroom would be locked. He described in some detail the admissions process at Leverton which included informing the young person of their rights, the complaints procedure and the routine during the day. There would then be a search process before the new arrival would be taken into the unit. Where a child was admitted and there was a risk of self-

[1121] WD006175
[1122] WS000608; WD006710
[1123] WS000608; WS006710
[1124] Day 84/71

harm they would be observed while locked in their room at night (locking in at night was standard for all residents).[1125]

4.886 Simon Bellwood said that young people should be the focus of all the work believing, " … *It's very empowering for a young person to feel that they're fully involved and that they feel that they have a degree of control and responsibility and empowerment over what happens to them, rather than feeling that everything about their life is dictated to them and that they're just a pawn in a game really*".[1126] For example, the default position in the UK was that the young person was always present at the review process. He noted that the new Greenfields building did not provide an independent meeting room where a young person, their social worker and parents could meet without compromising security.

4.887 Simon Bellwood told the Inquiry about his concerns relating to the admission process to the Greenfields Centre and the use made of Probation Orders: " … *it essentially had allowed the power of the Magistrate to be handed over to the social worker because the social worker was the one that could then change the address that the person had to reside in, rather than the Magistrate … the bigger concern was that they could hold the child in custody by virtue of their chosen residence*".[1127]

4.888 The default position in the UK was that the young person was always present at the review process. He noted that the new Greenfields building did not provide an independent meeting room where a young person, their social worker and parents could meet without compromising security.

4.889 He described as "*archaic*" the Greenfields review process in Jersey and said that *"the young person was pretty much not present*". The review process "*effectively determines whether they stay in secure accommodation".* He remembered that there were some policies in place when he took over but these were disjointed and some out of date: "*The whole thing needed*

[1125] Day 84/77
[1126] Day 84/82
[1127] Day 84/85

completely overhauling".[1128] When he came to Greenfields he developed management plans for an individual to help staff – these sat alongside care plans which were documents created with/by Children's Services. These plans had not existed before he came to Greenfields, though he stated that they might not have been warranted depending on the behaviours displayed.

4.890 Simon Bellwood compared the infrastructure of Leverton with Greenfields:

> "*In my view Leverton was more homely because they had doors that perhaps would not look dissimilar to what's in this room, but they're still built to a standard and have the same locking systems, etc etc, so they provide the same security and structural function, but from an aesthetic point of view I was very much of the belief that there is a distinct difference between a secure children's home and a young offender institute, by the very nature of how people are admitted and how people are cared for and balancing the fact that in a young offenders institute you do not get young people there who are there for their own welfare, whereas in a secure children's home you do, so if the building can be designed to take into account that you may get an 11-year-old female who is there for no criminal route whatsoever, then if I had been involved in the design of the building then making it homely would be one of the considerations and in my belief you can do that without compromise to security*".[1129]

4.891 Simon Bellwood provided the Inquiry with the final version of the behavioural management systems he introduced and which he had emailed to Joe Kennedy.[1130] He wanted to discard the "Grand Prix" system (the "*power of the key*") and to introduce a more therapeutic approach. Under his behaviour management system, negative behaviour was dealt with by denying rewards. Simon Bellwood told the Inquiry that it was a positive award system rather than one based on sanction.[1131]

4.892 He was asked whether the difference between himself and his critics at the time was due to a fundamental difference in ethos towards young people in the island with challenging and difficult behaviour. He replied, *"I think it goes broader than that. I think the culture of how to manage young people in Jersey is directed not only by the staff who work within the units, or the managers*

[1128] Day 84/88
[1129] Day 84/90–91
[1130] WD006710/71
[1131] Day 84/119

that run the units, also there is a degree of public demand and Jersey is quite a way behind bigger places like the UK in lots of areas … There's also a lot of funding issues, there's a lot of training issues … I think fundamentally the one thing that made it the most difficult was my relationship with Joe Kennedy and the fact that Joe Kennedy was essentially a prison officer and I was a social worker".[1132]

4.893 He believed that the culture towards young people is politically driven and change would have to come from the top down.[1133]

4.894 Simon Bellwood recognised that there were issues of scale for Jersey compared with the UK. The latter has specialised facilities as a suitable alternative to secure accommodation which it would not be possible for Jersey to have. As a consequence, he believed that young people might end up in Greenfields sooner than an equivalent child in the UK would in an equivalent facility. Staffing levels at Greenfields had been reasonable. Levels of staff training in Jersey were very different to those available in the UK; he did not think that this was necessarily excused by its being a small island. He told the Inquiry that those admitted to Greenfields for the most part would not have been admitted to secure accommodation in the UK.[1134]

4.895 Simon Bellwood said that children in Jersey lacked a voice regarding their placement. The same applied to complaints, "*if you do not believe that you have a voice and nobody is going to listen, why would you complain*?"[1135] Ironically a concern at his previous home had been the lack of complaints where there was a procedure for complaints; this had suggested that the complaints procedure was not robust enough. He hoped Jersey would by now have had a culture shift in this regard.[1136]

4.896 He said that external scrutiny was needed; there was a lack of external scrutiny or force to drive through change. There is a reliance on individuals to bring about change but those individuals may be fearful of losing their jobs.

[1132] Day 84/121
[1133] Day 84/123
[1134] Day 84/124
[1135] Day 84/148
[1136] Day 84/148

They do not have recourse to moving to another county/local authority (as in the UK).[1137]

4.897 Simon Bellwood's complaint to the Chief Executive of Health and Social Services Department was that Joe Kennedy had "*enforced a behaviour management procedure that can potentially involve locking a young person in a room (known as single separation) for over thirty-six hours*".[1138] In March 2007 Phil Dennett, Coordinator for SEBD Services[1139] prepared a report which included a review of complaints made by Simon Bellwood relating to the use of isolation. The report noted that the use of secure accommodation under Joe Kennedy's management reduced from 25 occasions in 2005 to nine occasions in 2006. Joe Kennedy said in evidence that the fall in numbers was "*because the relationships and running of the unit were much more positive*".[1140]

4.898 One member of staff who had worked under Joe Kennedy remembers Simon Bellwood's arrival and moving to the new Greenfields site, "*The day we moved to Greenfields we had a totally new behaviour system which ran well and had worked in Simon's previous post. … I think it went Gold, Silver, Bronze and Platinum or something like that … He did not agree with the twenty four hours in their bedrooms. He believed that the young person should come out automatically and mix with other young people. If there was a valid reason for them not to come out ie upset, or horrendous time before they came to us then I am sure he would not force them out. He thought there was no reason to keep young people in their bedrooms for hours*".[1141] When comparing having worked under both, she viewed the "Grand Prix" system as needed when "*the place was in crisis*" as it set "*very firm boundaries*". Simon Bellwood's system "*involved a lot of therapeutic skill that not everybody was ready to use because they had not had the right training*". She says that while Simon Bellwood was away, a new resident was admitted who was very challenging: there was a return to placing new residents in their rooms for 24

[1137] Day 84/149
[1138] WD005769
[1139] Children with Severe Emotional and Behavioural Difficulties
[1140] Day 72/12
[1141] WD005847

hours on admission. As at 2008, *"The twenty four hour secure does not happen at all now, we now have level one, two and three. Level one they have a radio in their room and 8 pm bedtime, that's for three days, level two they get a TV in their room, and bed at 8.30 pm and that lasts for seven days, level three they have 9 pm bedtime, a TV, PlayStation and a stereo in their room that lasts as long as".*[1142]

2007–2014

Management support for Greenfields

4.899 In 2007, a review of the policies and procedures at Greenfields was carried out by Linda Dodds, then Team Manager, Assessment and Child Protection.[1143] There was no evidence that safeguarding of young people or staff had been compromised. She reviewed the most recent admission process and concluded: *"It is important to assess each young person as part of the admission process and this required some degree of isolation for a short period of up to 24 hours*".

4.900 Linda Dodds provided an addendum to her report having met with Simon Bellwood. She concluded that there was no evidence that on admission a resident will be locked up and isolated for 24 hours.

4.901 WN854 was employed at Greenfields in 2007 and 2012; she worked under Joe Kennedy. In her statement to the Inquiry she said that one of her first jobs on arriving was to shred documentation mostly on the "Grand Prix" system. She says that she was asked to do so by Phil Dennett and Joe Kennedy as "*Simon Bellwood was opening an Inquiry*".[1144] She also recalled staff putting young children in the secure unit "*while they sat around cooking breakfast".*[1145] In responding to the allegation by WN854, Phil Dennett said that he had never asked her to do so and that specific paperwork relating to the "Grand Prix" system would only have been shredded if they were duplicates. He also pointed out that the issues raised by Simon Bellwood about the "Grand Prix"

[1142] WD005847
[1143] WD005847
[1144] Day 119/121
[1145] WS000684

system were already in the public domain at the point when WN854 took on her role.[1146]

4.902 The Greenfields Statement of Purpose and Function[1147] dated April 2013 set out the organisation of the centre, "*Greenfields Centre is a secure facility for young people aged between 10 and 16 years of age, and the building can cater for up to 8 residents at any one time. There are provisions for residents to be educated in classrooms on site with-in the secure environment. Greenfields Centre's main living quarters are divided into 3 corridors with the 1st corridor housing four rooms, the 2nd corridor housing two rooms, and the 3rd corridor housing a further two rooms. There are two rooms that have the ability of using cameras to monitor high risk residents, (the cameras are live feed and have no recording capability). On site there is a fully equipped gym a sports hall with a full and diverse range of sports on offer. There is an arcade area with a pool table, art room and also a movie and games lounge where the residents can socialise under supervision of staff*".

4.903 The Statement records that the Greenfields Centre provides single accommodation for up to eight residents between the ages of 10 and 16. It can provide accommodation for those who are disabled or who have special needs. It also provided an educational establishment, and all residents were expected to attend education at the specified times.

4.904 Admissions to Greenfields would usually be through either the criminal justice system or by an application to the Royal Court for a secure accommodation order made by the young person's CCO. Key workers are allocated to each resident and take responsibility for their care together with regular reviews of their placement and care plan. The staff team is set out but, unlike other "Statements of Purpose and Function", there is no evidence regarding qualifications or experience of staff members save for the Centre Manager. All staff receive comprehensive training on appointment and throughout their employment at the facility.

[1146] WS000708
[1147] WD008739

Findings: Greenfields

4.905 The Panel visited Greenfields Centre in 2015. We were concerned about the nature of the facility and the regime, as described to us at the time of our visit. We found the design and layout of Greenfields Centre was like that of a prison; we felt that the ethos remains one of control and containment. In our view, the ethos is not welfare based.

4.906 The States of Jersey is a very recent signatory to the *United Nations Convention on the Rights of the Child (1989)*. *Article 3* states:

> *"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or interested parties, the best interests of the child shall be a primary consideration".*

4.907 The Howard League's Review in 2008 highlighted difficulties with children's custody in Jersey and noted that "*There is far too high a level of custody, and we believe that measures should be taken to eliminate it*".[1148] The League concluded that: *"If our vision for the elimination of custody in Jersey comes to pass, there will be a greatly reduced use for the Greenfields Centre as a secure Children's Home, although it is likely that there will be a continuing need for "welfare" cases to be held there. But in any event, it is likely that thought needs to be given to a more flexible use of Greenfields and a great reduction in its use as a secure facility".*

4.908 We, in 2017, agree, and are concerned to be echoing those sentiments nine years later. There is an over-provision of secure accommodation (11 beds) for young people in Jersey, given the population of 100,000. We note that Joe Kennedy told the Inquiry that, on the date on which he was giving evidence (in 2015), only one young person was placed at Greenfields. By way of comparison, Edinburgh, with a population of 496,000, provides for only nine places. The existence of Greenfields reflects a cultural malaise on the island on the approach to young people who have become marginalised.

[1148] Paragraph 10.1b

4.909 The Howard League were also critical of the language and construction of the leaflet given to residents explaining the "Grand Prix" system, saying "*It is unlikely that most children would grasp the system".* We endorse the criticisms expressed by the Howard League. The "Grand Prix" system as applied at Greenfields between 2003 and 2007 was totally inappropriate for a setting such as Greenfields.

4.910 We consider that the changes sought to be implemented by Simon Bellwood were positive and necessary. We echo his sentiments that children in Jersey do not have a voice – or, at least, not one that is taken seriously or respected.

CHAPTER 5

The Political and other Oversight of Children's Homes and Fostering Services

5.1 In this chapter, we examine the political and other oversight of children's homes and fostering services, and other establishments run by the States (for example, Les Chênes), in the period under review (Term of Reference 3). We also examine the effect that the political and societal environment had on such oversight (Term of Reference 4).

5.2 With regard to political oversight, we have looked specifically at the oversight provided by: the Education Committee between 1960 and 1995; the Health and Social Services Committee between 1995 and 2005; and the Ministerial Government from 2005 onwards. These were the institutions that were legally responsible for children in care during the relevant time.

5.3 The primary sources of evidence for consideration of the political oversight of children's homes over the relevant period are:

- The minutes of the Committees, Sub-Committees and other oversight bodies.
- The evidence reviewed in Chapter 4 in relation to the governance of the individual homes.
- The oral evidence from individuals who were involved with political oversight at relevant times. This evidence does not provide a comprehensive understanding of political oversight across the whole period with which the Inquiry is concerned. It does, however, provide a first-hand account of some of the challenges, experiences and attitudes involved.

5.4 We have also looked at the Board of Governors for Les Chênes and the Board of Visitors for Greenfields, given their unique oversight role in that regard.

5.5 We then make specific findings as to the oversight of fostering services during the relevant period by Children's Services and the relevant Committees. We have set out the relevant evidence on this topic in Chapter 3, when establishing the type and nature of those services, but, as discussed in that chapter, we consider that the appropriate place for findings is here.

5.6 Finally, at the end of the chapter, we look at the operation and oversight provided by Children's Services during this period, which we consider to be important "other" oversight.

Political oversight of children's homes

5.7 The individuals with a role to play in political oversight, from whom we heard oral evidence during Phase 1bb of the Inquiry, are as follows:

- Keith Barette: Day 98; WS000634; WD007910;
- Ben Shenton: Day 99; WS000636; WD007917;
- Patricia Ann Bailhache: Day 99; WS000635; WD007912;
- Paul Le Claire: Day 100; WS000637; WD007924;
- Ron Maclean: Day 101; WS000633; WD007861;
- Bob Hill: Day 104; WS000515; WD005189; WD005190;
- Ann Pryke: Day 112; WS000638; WD008086.

Education Committee/Children's Sub-Committee (1960–1995)

<u>Keith Barette</u>

5.8 Keith Barette was a co-opted member of the Children's Sub-Committee (CS-C) from about 1977 to 1980. This was a voluntary position and, after two years in the role, Keith Barette was allocated responsibility for HDLG.

5.9 He told the Inquiry that the Sub-Committee did not set its own agenda, and dealt with issues as they arose. General child care issues were discussed, but

there was little interest in what was going on in the UK or elsewhere. Reports were received from the various homes.

5.10 Keith Barette said that the Sub-Committee was not involved in any discussion of policies and procedures for child care. The Sub-Committee would be asked to comment on issues, but the Education Committee made the decisions. The Sub-Committee's suggestions would generally be accepted, said Keith Barette, on smaller issues, but not on larger ones. He did not recall any discussion about child protection, non-accidental injuries or serious case reviews (SCRs). The members of the Sub-Committee simply attended a meeting once a month. There was no regular contact between Children's Services and the Sub-Committee.

5.11 Keith Barette said that he was enthusiastic, at the time, about the development of professional fostering. He was involved with some of the work done by Charles Smith in that regard (discussed in Chapter 3). He was disappointed at the reaction when their findings were presented to the Education Committee. He recalled John Rodhouse, Director of Education, questioning why he recommended eight people in a family unit rather than 12 to 14. He felt that eight was the maximum number that enabled professional foster parents to give each child sufficient attention. He said that it was his impression that budget was the main consideration and that professional fostering was regarded as more expensive than placement at HDLG.

5.12 He visited HDLG each week, speaking to children and staff and looking for small ways to improve the Home. Although he was able to speak to children without staff being in the immediate vicinity (for example, in the corridor), he never sought to communicate with them privately (i.e. in a separate room). He assumed that children would not have told him anything about abuse because they were fearful of repercussions. The staff told him that he was the only Committee member who spent time at HDLG.

5.13 Some staff, said Keith Barette, placed more emphasis on discipline than others, and some would tell him that they had "*put a child right*". He had no reason to believe that the children were being physically abused, and it would

have been difficult for him to raise concerns about discipline, as this would have amounted to telling professionals that they were not doing their jobs properly.

5.14 Keith Barette knew that children were kept in detention for 24 hours as a result of absconding. When asked by Counsel to comment on the Sub-Committee minutes noting that girls were placed in 48-hour solitary confinement, he said that he would not have considered it appropriate at the time.

5.15 Keith Barette provided a report to the Sub-Committee in which he raised concerns about staff turnover, the attention paid to *"poorly behaved"* children and the fact that HDLG was too large an institution.[1] He recommended to the Education Committee that a small sub-committee investigate the issues raised, but this never materialised. The Education Committee did not look favourably on his comments as they *"touched a nerve"*. He also felt that the closure of HDLG was not a priority, as it did not affect as many people on the island when compared with education matters. He suggested that a cynical perspective was that HDLG was not going to get politicians any votes.

5.16 He believed that the reason that he was not asked to remain on the CS-C in 1980, when his membership came to an end, was because of his criticisms.

Patricia Ann Bailhache

5.17 Patricia Bailhache was a Senator and then Deputy of the States of Jersey from 1987 to 2002. She was a member of the Education Committee for most of that period, and gave the following evidence about its work.

5.18 Each committee had seven members, and most members served more than one three-year term. The President, who appointed the members, was elected by the States Assembly. The Committee met fortnightly, and the agenda was prepared by officers. The Children's Officer reported to the Director of Education, who was accountable to the Committee.

[1] WD007910/14

5.19 Patricia Bailhache said that budgets were set by the Treasury and then assigned by the Director of Education. The focus of many members was on schools, although a few politicians were interested in Children's Services. Patricia Bailhache felt that, rather than a lack of "political will", there was a lack of appreciation by politicians of the role of Children's Services. She believed that the role of the Education Committee was to be supportive of the Children's Officer, and thought that their statutory responsibility towards children in care would have been explained by Anton Skinner. She explained that a "rating" system was in place for the passing of legislation, and she thought that pieces of legislation concerning children took a long time because they never had high enough ratings. She didn't believe that this was because finance was seen as being more important.

5.20 Patricia Bailhache chaired the CS-C from 1988 until the early 1990s, when it was disbanded at her suggestion. She said that it became clear to her that the Sub-Committee was achieving little and not providing any real scrutiny. It never challenged anything and only made recommendations.

5.21 The Sub-Committee met every three months and mainly discussed children who had been taken into care and what plans were being made for them. Some members visited the homes, but did not interact with the children. When she first joined the Sub-Committee, she visited all the homes and met the Houseparents at Family Group Homes (FGHs). She told the Inquiry about her impressions of the various homes and how they were run, including her positive impressions of Heathfield and Brig-y-Don (BYD) and her impression of Jane Maguire at Blanche Pierre being strict and *"overbearing"*. She did not think it appropriate, at the time, to relay her views to the Children's Officer or other members of the Sub-Committee.

5.22 As Chair of the CS-C, Patricia Bailhache was never told that the Children's Service was her "responsibility" and, on reflection, she said that the lines of accountability could have been clearer. She thought that Children's Services were the "poor relations" of the Education Department.

5.23 Patricia Bailhache felt that, as a "*critical friend*", she was able to exercise political oversight, although she acknowledged that she did not know everything that was happening at the time. She went on to say that the idea of "scrutiny" was not something that was around in 1988. She never considered calling in external inspectors.

5.24 In respect of specific issues arising during her tenure, she gave the following evidence:[2]

- **Clos des Sables.** She recalled a telephone call from John Rodhouse (Director of Education), who told her about the allegations of sexual abuse against Les Hughes, the Housefather. She was *"horrified"*. The Sub-Committee had no further involvement save to discuss measures to protect children in other establishments. There was no follow-up report on lessons to be learned. They trusted the Children's Officer to draw their attention to any action taken.

- **Blanche Pierre.** She had no recollection of hearing about the allegations against the Maguires or of seeing the letter from Iris Le Feuvre[3] praising their 110% commitment as Houseparents (discussed in Chapter 9). When the Maguires left Blanche Pierre, Anton Skinner informed her that Alan Maguire was a *"sick man*" and that Jane Maguire was moving to the administration team at Children's Services. Patricia Bailhache did not question whether the move was appropriate. She said that the concerns raised about the Maguires' treatment of the children at Blanche Pierre should have been provided to her in detail, and that she would have expected an internal investigation at the time. She would not have been fazed by hearing of slapping children on the legs, but would have been disgusted at the Maguires washing children's mouths out with soap. She thought that the Education Committee was not responsible for the actions of Alan Maguire, as he was not employed by them.

[2] We analyse the issues themselves in Chapter 9
[3] Chair, Education Committee (1990)

- **Heathfield.** She recalled being shocked about the allegations of sodomy made against WN335, but had no specific recall of Anton Skinner's note to her regarding the allegations. In her witness statement, Patricia Bailhache said that WN35's recommended early retirement was the *"tidiest*" way to deal with the situation. In oral evidence, she said that this may have been "*unfortunate phrasing*", but that this was a system still in place today. She thought that, in hindsight, the Education Committee should have exercised independent scrutiny in respect of WN335. There was no discussion, as a Committee, as to whether outside authorities should be alerted about WN335's behaviour.

5.25 In response to a question from the Panel, Patricia Bailhache said that, notwithstanding these significant issues (within the space of two years), she did not question the competence of the Children's Officer. Furthermore, no-one suggested a full inspection or review.

5.26 After the Sub-Committee was disbanded, Children's Services remained her responsibility, and she met with Anton Skinner informally on a monthly basis. When Children's Services transferred to the remit of the Health and Social Services (HSS) Committee in 1995/96, Patricia Bailhache ceased to have responsibility for the service. She remained on the Education Committee, which retained responsibility for Les Chênes, but it did not fall under her specific remit.

Health and Social Services Committee (1995–2005)

Bob Hill

5.27 Deputy Bob Hill was a member of the HSS Committee from 1998 to 2005. He told the Inquiry that the Committee did not provide adequate oversight of children's homes because it was not given the information to do so. Anton Skinner, as Head of Children's Services, was one of the officers who attended every meeting, but he thought that Committee members were not well enough informed to ask officers relevant questions. The Committee, by way of example, was unaware of the problems identified by Dr Kathie Bull until her

first Report was published. In February 2003, Bob Hill raised his concerns about the lack of information provided to the committee.[4]

5.28 Bob Hill said that the Committee tended to focus on health, rather than social services issues.

Paul Le Claire

5.29 Paul Le Claire was a member of the States of Jersey, as a Deputy and then Senator, from 1999 to 2011. He was a member of the HSS Committee from June 1999 to 2005.

5.30 Paul Le Claire told the Inquiry that the Committee met between 10 and 12 times per year. There was no principle of collective responsibility, but it was deemed inappropriate to speak out of harmony with others. Paul Le Claire recalled that, during meetings, the minute taker would sometimes be asked not to record certain points – usually when something controversial was raised. This, he explained, applied even to the confidential part of the meetings, which should still have been minuted.

5.31 Paul Le Claire gave evidence about an occasion in about 2000/2001, when it was announced *"this is not for minuting … if we can ask the officer to … bring us up to date with the X children"*. He recalled that Anton Skinner then gave an oral report about the abuse of a group of children, saying that their home was an "*open house*". Anton Skinner said that the Police were aware of the situation and that the last thing that Children's Services wanted to do was remove the children from their parents. Paul Le Claire said that, mindful of the evidence coming to light during this Inquiry, he now suspected that the Police might not have been informed at the time. Paul Le Claire said that, following Anton Skinner's briefing, members were given the Child Protection Procedures dated December 2000.[5] He did not recall any further updates on the children.

[4] WD005224/10
[5] WD007924/40

5.32 Anton Skinner, in response to this evidence about his alleged oral report to the Committee, said that he had no recollection of this event.[6] He said that, as a matter of practice, any request from him not to minute something would be limited to names of families and children.

5.33 On reflection, Paul Le Claire thought that the Committee had insufficient oversight. Politicians relied upon officers and departments to safeguard children, and safeguarding "*needed to be strengthened by some other mechanism".* Scrutiny Panels[7] were not enough. There were appraisals about issues relating to social services, but the Committee's primary focus was on health. Social services was the *"weaker brother".*

5.34 Paul Le Claire believed that the committee system was better than the ministerial system because, with the latter, decisions rested with one individual. Furthermore, the committee system gave directly elected politicians a degree of responsibility and accountability. He described the culture within the States of Jersey as a "*culture of fear, control and cover up*". He said that "*speaking out is not done*" and that concerns would be ignored, particularly if they threatened Jersey's reputation.

Ministerial Government (2006 onwards)

Ben Shenton

5.35 Ben Shenton was elected Senator in 2005 and appointed Minister for the Health and Social Services Department (HSSD) in 2007. He held this post until 2009. He believed that he was seen as independent and, although his appointment initially met with some resistance, he formed a healthy professional relationship with the Chief Minister, Frank Walker. His personal experience was in investment management, and he said that he was not qualified to give an opinion or to direct how Children's Services should be run; that was "*up to the experts in that field".* He said that, although reviews were being carried out, "*My input would have been meaningless and may well have*

[6] WS000734/17
[7] Scrutiny Panels existed during Ministerial Governmen

pushed the department in the wrong direction". The role of the politicians, he said, was to implement the policies of the States of Jersey.

5.36 He described Jersey as having a unique system of government in which, despite the ostensible independence of politicians, progress depends upon moving within establishment circles. It was his view that Senator Stuart Syvret's removal as Minister for Health and Social Services (discussed in Chapter 10) was because he was *"too outspoken and challenged things publicly that the State would rather keep under wraps"*.[8]

5.37 Ben Shenton thought that, as Minister, he achieved three key things: (i) continuing the appointment of Professor June Thoburn to the Jersey Child Protection Committee (JCPC), which had been initiated by Senator Stuart Syvret; (ii) appointing Andrew Williamson to undertake a review of child protection practice; and (iii) inviting Jim Perchard to be Assistant Minister with sole responsibility for Social Services. Ben Shenton thought that that ensured specific representation for the service within the Council of Ministers, distinct from health issues. Due to objections within the Council, they were not permitted to attend the same meetings, and therefore Ben Shenton absented himself if he thought that there was an issue that Senator Jim Perchard should address. He described Senator Jim Perchard as someone who was "*very proactive"*[9] and who had a difficult role in ensuring that social workers and other staff within the Department could carry on with their jobs despite being demoralised by the political saga and Operation Rectangle.

5.38 Ben Shenton described Social Services as under-resourced and a "*dysfunctional and fractured arrangement which lacked responsibility*".[10] In January 2008, he wrote[11] to the Chief Minister,[12] setting out his concern that Children's Services was not fit for purpose, and that there were difficulties with accountability and departments operating in silos.

[8] Day 99/144
[9] Day 99/147
[10] WS000636/6
[11] Although he believed that it was drafted by Chief Executive of the Department, Mike Pollard
[12] WD007917/17

5.39 The HSSD had a fixed budget from the States of Jersey, and health was the funding priority. He said that funding lacked strategic planning and there was no analysis of the actual cost of providing necessary levels of care.

5.40 Ben Shenton had limited involvement with Greenfields, but agreed, to an extent, with Simon Bellwood's criticism of the "Grand Prix" system, which he thought was outdated. However, he described these criticisms as a *"storm in a teacup"*. He provided a report to States members, entitled "Greenfields – Time for Truth",[13] which he thought provided a more balanced account of the real issues at Greenfields.

5.41 He appointed Andrew Williamson to undertake a review of child protection practice and he welcomed his recommendations, in particular for the appointment of a Children's Commissioner/Minister. Ben Shenton left before implementation but was assured by the Chief Minister that the recommendations would be implemented in full. He said that he was surprised that full funding was not given and that, had it been a "health" issue, funding would not have been a problem. There was a tendency, said Ben Shenton, to allocate resources to management rather than frontline staff, as had been found in the Breckon Report of 2009 (the Co-ordination of Services for Vulnerable Children Sub-Panel Review). He also said that he did not disagree with the finding that the Williamson Report had not gone far enough.

5.42 Ben Shenton also gave evidence about his ministerial role in the context of Operation Rectangle, recalling that he felt extremely angry at the Police for misleading the public. Ben Shenton was taken to a series of emails[14] expressing his views about the oversight of the States of Jersey Police (SOJP) by the Home Affairs Department; to which he said: "*All I wanted the Police to do was to stop speculating and just report the facts."* As Minister, he said that he gave his Department instructions to co-operate fully with the investigation. He said that he was not asked to become part of the advisory

[13] WD007917/36 – again, he believed that it was drafted by Mike Pollard
[14] WD007913; WD007915; WD007914; WD007916

group during Operation Rectangle, and said: "*I'm not quite sure what political oversight actually means."*[15]

5.43 When his tenure as Minister expired, he was asked to step down by the new Chief Minister, Terry Le Sueur. He believes that this was because he put pressure on the States to get things done, and this had made it too difficult for them.

Anne Pryke

5.44 Anne Pryke became a Deputy in 2005 and, in April 2009, upon the resignation of Senator Perchard, she became Minister for Health and Social Services. She held the post until 2014.

5.45 Deputy Anne Pryke told the Inquiry that health care matters had a bigger profile than Social Services, but Children's Services were an important part of her portfolio and she allocated her Assistant Minister specific responsibility for children, and looked after children in particular. The appointment was made, in part, as a response to the Williamson Report.

5.46 The management structure of Children's Services was *"unwieldy*" when she took up her post. There were no clear lines of accountability and she had no *"grasp"* on who was running Children's Services and Social Services.

5.47 The corporate parent, responsible for children in care,[16] comprised the Ministers for Home Affairs, Health and Social Security, and Education, Sport and Culture. Deputy Anne Pryke described one meeting as a *"shambles"*. She said that no-one wanted to take responsibility for anything, and she thought that a new direction and strong purpose were needed.[17] She thought that the corporate parent system was not working and the Youth Action Team (YAT) and the Children's Executive were not particularly effective.

[15] Day 99/184
[16] By this time referred to as 'looked after' children
[17] WS000638

5.48 The corporate parent system and these other groups subsequently evolved into the Children's Policy Group, which is chaired by the Assistant Chief Minister and includes the Assistant Minister responsible for children, the Minister for Health and Social Services, the Minister for Home Affairs, the Minister for Housing and the Minister for Social Security, and others.[18] From this time, Deputy Anne Pryke, as the Minister for Health and Social Services, took over sole responsibility as corporate parent for looked after children.[19] She said that she saw her responsibility as corporate parent:

> *"to care for the best needs of looked-after children and young people as if they were mine, what's best for them and what's right for them".*[20]

5.49 Deputy Anne Pryke believed that multi-agency working led to greater openness and accountability. Each agency, she said, approached an issue from a slightly different perspective, willing to challenge decisions while working together for the best outcome for child and family. Throughout her written and oral evidence, she emphasised that politicians set policy and that it was the duty of line managers to implement policy and support staff. She did not recall anything being put in place to check whether policy was in fact implemented.

5.50 In August 2007, Andrew Williamson was appointed by the Chief Minister and Council of Ministers to undertake an investigation into issues relating to child protection in Jersey. The Inquiry was considered necessary following a number of serious allegations of malpractice, particularly within the Children's Service, made by a former Minister for Health and Social Security (Senator Syvret) and other complainants.

5.51 Andrew Williamson presented his report in June 2008, an implementation plan was delivered in January 2009, and a Sub-Panel was then set up to review the plan and related issues. The Sub-Panel presented its report (also known as the "Breckon Report") in July 2009.[21] One of its appendices was a critique

[18] Day 112/11–13
[19] WS000638/14/44
[20] Day 112/30/2–4
[21] WD006407

of the Williamson Report by Professor Ian Sinclair, who identified a number of omissions from the Report. One of his findings was that Andrew Williamson failed to give consideration to the prevalence and scale of child abuse in Jersey.

5.52 In October 2009, Deputy Anne Pryke published the Minister's response,[22] most of which, she told the Inquiry, was drafted by civil servants because it involved operational matters. She told the Inquiry that she initially understood that the Implementation Plan was fully funded, the Council of Ministers having put funding in place in January 2009, before she became Minister.[23] It was only some time later that she learned that the Council of Ministers had decided, in January 2009, not to proceed with some aspects of the plan. She said that she did not at any stage go back to the Council and ask for funds to implement the plan in full. She said that no officer had told her that there was insufficient money to implement an adequate system; she did not ask about funding but would assume that, if officers believed that there was a need for more money, they would supply her with a briefing paper.[24] In evidence, she said that efforts to recruit staff were the responsibility of the Human Resources Department and an operational one (not for a politician). As Minister, she did not initiate any move to examine the issues identified by Professor Ian Sinclair. She expected the Safeguarding Board to take action in that regard.

5.53 The Sub-Panel Report had recommended a pan-departmental Children's Plan as being essential to the delivery of children's services. The Minister's response was to say that she agreed but intended to extend the plan to be an island-wide Children's Plan, which would include all relevant charitable and voluntary organisations. Deputy Anne Pryke told the Inquiry that, in fact, the plan was not created; there was no underlying strategic framework, which would have been necessary to underpin the plan, so her Department went back to create that framework. She said that the idea of a Children's Plan had

[22] WD008086/374
[23] Day 112/49-50
[24] Day 112/91-2, WS000638/16/49-51

"evolved" and that the work under the strategic framework, across the departments, had been done.

5.54 The Ministerial Response had stated that work would begin immediately to commission sections of the Children's Plan, based upon UK best practice. When asked what, if anything, was done to identify such best practice, she said that it was done on an operational level – by sharing and networking, attending conferences and reading information. She had attended a couple of conferences herself, including one on safeguarding.

5.55 In her oral and written evidence, she provided further details of the appointment of an independent reviewing officer, the upgrading and refurbishment of children's accommodation and the provision of support to care leavers to the age of 25; these were all matters discussed in the response document on which action was subsequently taken.[25]

5.56 Deputy Anne Pryke initiated inspections of Children's Services by the Scottish Care Inspectorate. She did not know whether funding for inspections continued after her tenure as Minister. A service level agreement was set up with the Jersey Care Leavers' Association (JCLA) to provide for children's advocacy and an independent visitors' service. Deputy Anne Pryke said that she discovered, through the work of the Scottish Care Inspectorate, that some States members were unaware that the States had parental responsibility for children in care. As a result, she set up presentations for States members, given by a variety of agencies. Visits to children's homes and to Greenfields were also arranged. She said that she would like to think that, during her tenure, she had managed to improve the knowledge of States members. However, she also said that attendance at the presentations was very low.[26]

5.57 She said that a business plan and sufficient funding were required to establish professional fostering. Departmental budgets were set for three years. In December 2015, she thought that the Department was going through the

[25] Day 112/80–84
[26] Day 112/21–24

process of establishing professional fostering, with the funds allocated in 2014's medium term financial plan.

Findings: Political oversight

5.58 In our view, the level of political oversight of children's homes by the Education Committee and its successors was inadequate.

5.59 The various committees and professional officers failed to formulate adequate or sufficiently adequate policy or legislation. The focus was on individual cases and, on consideration, in our view unprofessional, of the details of children and related family circumstances in unredacted personal files. We acknowledge the reasons provided by Patricia Bailhache for delays in legislating and that some delays would be explicable due to the relatively small administrative scale of Jersey, however there is no good reason why the *Children (Jersey) Law 1969* was passed over 20 years after its English counterpart, and the *Children (Jersey) Law 2002* passed over 10 years after its counterpart.

5.60 From the late 1970s, the CS-C was largely ineffective at carrying out any oversight. They did not discuss any policies and procedures for child care and had no regular contact with Children's Services. Keith Barette was the only Committee member who spent time at Haut de la Garenne and showed some insight into the needs of children, but his concerns about the Home were largely ignored and he was not asked to remain on the Committee.

5.61 It is telling that Patricia Bailhache, a longstanding member of the Education Committee and the Chair of the CS-C, thought that their role was to be supportive of the Children's Officer. Although we note Patricia Bailhache's comments that the concept of "scrutiny" did not exist in the late 1980s, in our view the Committees did not properly carry out their role as "critical friend". They had a statutory responsibility for children in care, but we do not think that they took adequate steps to ensure that these children were being adequately cared for. One of the primary reasons why they failed to carry out their oversight role effectively is that there was a lack of understanding about what their role should have entailed and what oversight actually meant.

5.62 Disbanding, rather than reforming, the CS-C in the early 1990s is likely to have reduced the focus on Children's Services within the Education Committee.

5.63 Patricia Bailhache said in evidence that she never considered calling in external inspectors. In fact, there was no external inspection of children's homes or children's services for approximately 20 years – between the Lambert and Wilkinson Report in 1981 and the first report of Dr Kathie Bull in 2001. This is unacceptable and inadequate for the standards of the time.

5.64 The lack of external inspection during this period is particularly concerning given that, between 1989 and 1991, there were three separate homes in which significant allegations of abuse had been made. Les Hughes was convicted of sexual offences in 1989, the Maguires left Blanche Pierre following allegations of physical abuse in 1990, and WN335 was forced out of Heathfield in 1991 following serious allegations of sexual abuse. Despite this, and despite the fact that these facts were known to Children's Services (and in two cases, known by the Committees themselves) there was no internal review, no inspection, and no questioning of the Children's Officer's competence. We consider that this was a failure of political oversight.

5.65 As recorded by various witnesses, Children's Services were the "poor relation" of the Department within which they existed, whether Education or Health and Social Services. This ensured that budgets remained a problem for many decades and that sufficient attention was not paid to children in care. Whilst we acknowledge that the responsibility for this lies, to an extent, at a higher political level, we consider that members of the Committees had a responsibility to lobby for greater importance to be attributed to children's services.

5.66 During the period in which the Health and Social Services Committee was responsible for oversight of children's homes, we saw very little discussion of children in care in the minutes. Members may not have been sufficiently informed to ask relevant questions of officers such as Anton Skinner, but they also had a responsibility to seek proactively that information. We note that the

Committee was unaware of the problems identified by Dr Kathie Bull until her report was published. All of this demonstrates that oversight was inadequate. The Committee's role was a passive one.

5.67 Under Ministerial Government, the poor level of oversight remained unchanged. When Ben Shenton became Minister, he demonstrated a proactive approach in appointing an Assistant Minister with specific responsibility for Children's Services and in writing to the Chief Minister, setting out his concerns that Children's Services was not fit for purpose. However, by the end of Ben Shenton's tenure as Minister, there remained fundamental problems within Children's Services in that there were no clear lines of accountability and no proper oversight of the unwieldy management structure.

5.68 During Deputy Anne Pryke's time as Minister, she recognised the failure of the corporate parent system in that no one party wanted to take responsibility for anything. The evolution into the Children's Policy Group, which had sole responsibility for children in care, was a positive step; however, there remained inadequate oversight.

5.69 Another apparently positive step during this more recent period was the commissioning of a large number of reports concerning children in care, although this was largely a reaction to the concerns raised by Senator Stuart Syvret and the publicity caused by Operation Rectangle. This at least moved Children's Services up the political agenda. However, there remained a failure to respond adequately to recommendations.

5.70 The States of Jersey failed to understand and fulfil its role as corporate parent to those vulnerable children in its care.

5.71 Children's Services was not given sufficient priority in time, funding and attention.

Other oversight

Governing Body/Board of Visitors – Les Chênes/Greenfields

5.72 Ron McLean was, from 1997 to 2009, a member of Les Chênes Board of Governors and its later incarnation, the Greenfields Board of Visitors. He was Chairman for most of this period. There was no interview for appointment; the only criterion was that members were "of good standing".

5.73 In 1999, as Chairman and during a sabbatical from work, he visited Les Chênes each week and discussed general issues with WN109, who was in charge at the time. These visits were unannounced. He did not speak to residents on their own, and did not ask to see the secure unit logs. After his sabbatical, he only visited Les Chênes on a monthly basis for meetings of the Board. Some Governors had specific duties, such as accommodation and placements outside of Les Chênes, but he saw his role as Chair as being to ensure that the establishment was well run financially.

5.74 The Governors theoretically reported to the Director of Education but, according to Ron McLean, they "*very rarely met with him*". The Governors had no input into the setting of budgets. Ron McLean said that the Director of Education (Tom McKeon, at that time) was their only link to the Education Department and that, other than writing to him, there was not much that they could do. When asked about the Governors' obligations to put the policies of the Education Committee into effect, he said that he was not aware of the "aims and policies" of Les Chênes. They relied on the Principal to tell them "*if the needs of the residents were being met*" and "*if we were told everything was fine, just accepted that*".[27] There was no discussion about policies on restraint, complaints procedures, behaviour management or secure rooms.

5.75 Ron McLean said that the Governors recognised concerns about overcrowding at Les Chênes, arising from the remand system. He told the Inquiry that he was first aware of these issues in 2000. However, we note that

[27] Day 101/33

there are minutes from 1997 recording concerns about overcrowding. At the time, he explained, he "*just didn't realise it was like that*".[28] He wrote to Tom McKeon, expressing the Governors' concerns, but could not recall receiving a response.[29]

5.76 There is a record of a meeting during which Ron McLean said that Les Chênes was going from "*crisis to crisis*"*.* In evidence to the Inquiry,[30] he said that everything seemed fine on visits, other than the overcrowding. The Governors never lobbied Tom McKeon for more resources. Although he had concerns that staff were unable to cope physically with some of the residents, he did not do anything about those concerns.

5.77 In 2001, allegations of assault were made by and against WN543 and WN245. The SOJP were notified and concluded that it was not in the public interest to proceed to prosecution. The Governors, said Ron McLean, were quite sure that there had been no wrongdoing on the part of WN543 or WN245 and wanted to ensure that nothing detrimental was recorded on their human resources files. He did not recall any internal investigation by the Governing Body and believed that it was the SOJP's responsibility to investigate. Ron McLean could not answer the question as to whether the Governors had an obligation to ensure that young people at Les Chênes were safeguarded from the risk of physical harm. He was also unable to assist the Inquiry about any steps taken to ensure that risk was minimised following the incident in 2001.

5.78 In his statement to the Inquiry, Ron McLean described the residents as *"young villains",* although in oral evidence he said that those admitted via the welfare route were better described as *"unfortunate young people"*. He was aware that young people on welfare placements and those on remand were in the same unit and, in hindsight, supposed that he should have had concerns.

[28] Day 101/53
[29] WD007861/5
[30] Day 11/47

5.79 He disagreed with the finding of a report from 2001[31] that there was no effective oversight of Les Chênes, but said that they were reliant on staff to tell them about issues. He agreed, to a certain degree, that the Governors were ineffective in taking action following suggestions made by individual members, but said that the power lay with the Director of Education and the Education Committee and the Governors were, to an extent, toothless. He did not recall being aware of the report at the time, despite the minutes of the Governing Body recording that he acknowledged the inspection at the time. He thought that the points/merit award system worked well and was a successful tool for managing challenging children. The Governors were unaware that policy/child protection needed improvement. He suspected that *"absolutely nothing"* would have been done in light of the criticisms made in the report.

5.80 In response to Dr Kathie Bull's Report[32] and her reference to locking children up as *"legally dubious methods"*, he said that the Governors had no concerns that it was illegal and thought that it was sometimes the best option for that child. He was not aware that staffing levels were problematic and that residents were being kept in secure rooms so that staff meetings could be held.

5.81 Dr Kathie Bull's Report had suggested that the Governors were aware of the concerns about Les Chênes over a long period of time and did nothing about those concerns, in response to which Ron McLean repeated his assertion that the Governors had no power and, although they could raise issues with the Director of Education, they had to rely on him to take matters further. On reflection, he accepted that the Report was "*quite damning in a number of areas*" but said that he was unaware of the scale of the issues at the time.

5.82 The Board of Visitors for Greenfields was formed in 2004, replacing the Governors and modelled on the prison system. Ron McLean said that, in practice, this simply amounted to a renaming of the existing body. He saw

[31] WD007861/32: "Validated School Self Evaluation Summary Report"
[32] WD007861/38

their duty as looking after the welfare of children and investigating complaints. There was no formal complaints process, and complaints received related to trivial issues about facilities or food. Ron McLean did not recall any reports of ill treatment. They could not meet one on one with a child, for *"safety reasons"* and he accepted that it was perhaps unrealistic to expect a young person who was concerned about mistreatment to approach one of the Visitors. Ron McLean said that the Visitors never gave any consideration to other channels that they could give to young people to express their concerns and they just hoped that, although it might be difficult for young people to approach the Visitors, they would do so.

5.83 Ron McLean said that it was unclear to whom the Visitors were accountable; they felt frustrated and as if nobody from the HSSD knew that that they existed. He was under the impression that they reported to Phil Dennett on the Children's Executive, but there was no sense of responsibility or accountability from him. The Visitors hardly ever saw him and, according to Ron McLean, he appeared to take no interest in what they did.

5.84 By 2006, he thought that the relevant agencies had got their act together and that the unit was well run under Joe Kennedy – he said that any discipline was necessary because the children were "*mischievous little devils*"[33] and that the "Grand Prix" system was fair. He disagreed with Joe Kennedy's assertion in evidence that the Visitors were out of touch with the children, but accepted they were probably not effective.

5.85 In response to the criticisms made by the Howard League for Penal Reform, Ron McLean said that their comments on solitary confinement were *"rubbish"*. The systems in place were necessary. He was unaware of a culture of fear among staff about raising concerns. He disagreed with the assertion that staff were unaware of the function of the Visitors, and he liked to think that the staff would have explained the Visitors' role to the children properly when they visited.

[33] WS000633/21

5.86 Ron McLean said that he and the other members of the Board of Visitors resigned around 2009, following suggestions that their responsibility would extend to oversight of Heathfield and La Preference, and that offenders from La Moye might be sent to Greenfields.

5.87 Ron McLean reflected on his role as a member of the Board of Governors and the Board of Visitors. He said that there was a general lack of co-ordination within Social Services that prevented them from being more effective. When asked whether the Governors and Board of Visitors provided effective oversight, Ron McLean initially said that he thought that they had done a good job, but following his oral evidence to the Inquiry: *"I don't think we did."*[34]

Findings: Other oversight of Les Chênes/Greenfields

5.88 The Board of Governors for Les Chênes and the Board of Visitors for Greenfields did not carry out effective oversight of the way in which these institutions were being run.

5.89 Although there were a number of visits to Les Chênes by the Governors, at least for a period of time, they did not speak to children on their own and thus could not have realistically expected this to provide any real opportunity for residents to make complaints. We are sceptical whether children would have made complaints to the Governors in any event.

5.90 The Governors were not aware of the "aims and policies" of Les Chênes and if the Principal told them that everything was fine, they would simply accept that. They did not scrutinise policies on important matters such as restraint, behaviour management or complaints. We consider that they failed to act as a "critical friend" of Les Chênes, which would have been central to the discharge of their role as Governors.

5.91 Despite significant concerns about overcrowding and crises at Les Chênes in the late 1990s and early 2000s, the Governors never lobbied the Director of Education for more resources. This was an inadequate discharge of their role.

[34] Day 101/86

5.92 Contemporaneous records from 2001 show that, following an incident between two staff members and a resident at the Home, the Governors automatically assumed that the staff members had been in the right. Their primary concern was that there was no detrimental effect of the allegations made against the staff members, rather than taking any steps to ensure that the residents were safeguarded from risk of physical harm. This attitude, which we consider was inappropriate for a Board of Governors, can also be seen in Ron McLean's description of residents as "*young villains*" in his statement to the Inquiry. The Governors were not carrying out their oversight role appropriately or effectively.

5.93 We agree with the 2001 Self-Evaluation Report's finding that there was no effective oversight of Les Chênes, which is supported by the evidence of Ron McLean that nothing was done in response to the criticisms made in that report.

5.94 Dr Kathie Bull's Report was damning about Les Chênes and suggested that the Governors had been aware of the problems over a long period of time and had done nothing about those concerns.

5.95 Following the Bull Report, Les Chênes was renamed Greenfields and the Board of Governors changed into the Board of Visitors. Although Ron McLean said that they saw their duty as looking after the welfare of children and investigating complaints, there was no formal complaints process and no real ability for children to express concern about mistreatment – there remained no one-on-one visits.

Findings: Political and other oversight of fostering services

5.96 We set out here the findings on the political and other oversight of fostering services as they fall within Term of Reference 3, however the relevant evidence is contained in Chapter 3 above.

5.97 From at least 1949, the States of Jersey's preferred policy was that children be placed in foster care as opposed to residential care. This was reinforced as

a statutory preference in the *Jersey (Children) Law 1969*. This was in keeping with the standards of the time.

5.98 Lack of legislative regulation of the fostering of children in care until 1970 was unacceptable.

5.99 The Children's Officer's was wrong to assert, in 1979, that the Children's Department had a *"minimal role to play"* in private fostering, with *"none of the stringent procedures"* required for those boarded out. In fact, there was an explicit duty, under *Article 57 of the 1969 Law, "to satisfy themselves as to the wellbeing of the children"*. As discussed in Chapter 9, following the death of a child in private foster care that year, a report was carried out that recognised the failings in having differing standards for children in private foster care to those who had been boarded out by the States of Jersey.

5.100 The level of boarding-out allowances over most of the period was consistently too low to attract a sufficient number of suitable foster parents, particularly when coupled with societal issues specific to Jersey, such as high housing costs.

5.101 Fostering systems in Jersey were incoherent, at least up to the early 1980s when David Castledine was appointed as Fostering Officer. However, even at this point, David Castledine was the only person given a specific fostering role within Children's Services. He was provided with no team to support him and he retained his caseload as a child care officer (CCO), meaning that he could not dedicate his time to fostering services. This demonstrates inadequate oversight of fostering services, particularly given the legislative preference for fostering of children in care.

5.102 We note that a Fostering Panel was not set up until 2001. This was inadequate according to the standards of the time and was contrary to good practice in the UK and in Guernsey.

5.103 Since the 1980s, there has been a continuous failure properly to implement professional fostering in Jersey. In the early 1980s, it was noted that plans would flounder due to lack of basic groundwork and adequate staff.

Considerable work was put into this by Children's Services. However, there was no political support. As Keith Barette said, it would appear that budget was the main consideration and that professional fostering was regarded as more expensive than placement at HDLG (or other children's homes). By the 2000s, failings continued due to largely the same reasons – a lack of political will and insufficient funding. We find that this failure demonstrates inadequate oversight of fostering services.

5.104 On the basis of evidence heard during Phase 3, we note that there remains a lack of support, guidance and training available for foster carers, and inadequate communication.

Children's Services: oversight and operation

Introduction

5.105 In the opening stages of the Inquiry, Tony Le Sueur gave evidence about the provision of support for children prior to 1958.[35] Richard Whitehead, Principal Legal Adviser, set out the history of the legislative provision.[36] It appears as Appendix 7.

5.106 The appointment of a Children's Officer in 1959 was consequent upon the publication of the Education Committee's "Memorandum with regard to Child Welfare", published in 1958.[37]

5.107 Under the heading "Present Situation", the existing organisation and management of provision for children as it then stood in the island was set out. Proposals for changing administration and staffing were put forward, based on "*the practice in England since the passing of the 1948 Children Act"*. The key to reform was identified as *"the appointment of a trained and experienced Children's Officer"*. The Memorandum also advocated the setting up of a Children's Committee, answerable in turn to the Education Committee. The Education Committee acknowledged that reforms in England resulted

[35] Day 4, EE000038/1
[36] Days 10 and 15, EE 000261
[37] Day 4, EE000038/1

from *"the Curtis Report and the passing of the 1948 Children's Act"*. Aside from the creation of the new roles of Children's Officer (CO) and CCO, the *1948 Act* had given statutory force in requiring a local authority to *"secure the provision of adequate staff for assisting the children's officer in the exercise of his functions"*.[38]

5.108 Patricia Thornton, Jersey's first CO, was in post by February 1959. She had a social service certificate from the London School of Economics and in the years prior to her appointment was Assistant Children's Officer (Field Work) with Nottinghamshire County Council. At an early stage in her appointment the Education Committee resolved that it would fund the CO's attendance at the annual conference of the Association of Children Officers and that she should attend regularly professional conferences in *"connexion with children's welfare"*.[39]

5.109 Known initially as the "Children's Section of the Education Committee", Children's Services[40] produced its first annual report in 1959, recording the appointment of its first CCO. Patricia Thornton then produced an annual report for the "Children's Section" until 1969, recording the level of caseloads, the scope of the work involved and the gradual increase in demand for intervention by the Children's Section. By 1968, the Children's Section had become known as the "Children's Department", although it was still commonly referred to as the "Children's Section" (or more latterly "Children's Services") over the next 20 years. Its primary focus remained the oversight of children taken into care and placed in residential or foster homes. Its preventative work, namely providing support to families to avoid the need for reception into care, was seen as an important aspect of its task: "*The CCOs spend much of their time in giving supportive social case work to families who are experiencing difficulties of many different kinds.*"[41]

[38] See *Children Act 1948*, section 41
[39] WD006833
[40] The title "'Children's Services" is a recent change within the context of the period with which the Inquiry is concerned
[41] EE000064

5.110 In 1964, the Home Office carried out an inspection[42] of what the report called "*Jersey's Children's Department, reviewing the 'miscellaneous social work' carried out by the Department*". At that date, the Children's Officer had one assistant and three CCOs. The Report described the Department as "*an all-purpose agency, attempting work which in England and Wales is usually shared with other local authority departments and with numerous voluntary organisations which are not represented in the Island; in addition, work to which many authorities on the mainland gave scant attention until the Children and Young Persons Act 1963 laid on them the duty and extended their power to promote the welfare of children by diminishing the need to receive children into or keep them in care".* Reference in the report to "*the pressure under which the Department was so obviously working*" suggests that resource had already become an issue of particular significance. Indeed, the evidence we heard suggests this to have been the case over the next 50 years.

5.111 In May 1970, the Home Office carried out a further inspection, which by then had been running for over 11 years.[43] This further inspection appears to have been at the invitation of the States. In the UK, the Home Office, then responsible for child care, had established an inspectorate with a duty to report back to the Secretary of State. At the time of the creation of the Children's Section in Jersey, an arrangement had been "*made with the United Kingdom that the services of the Inspectorate could be available by invitation of the States*".[44]

5.112 In the intervening period between the two inspections, the *Children (Jersey) Law 1969* had come into force, imposing statutory duties relating to the registration and inspection of voluntary homes, including children's homes, as well as a range of statutory bases for the admission of children into care among other wide-ranging reforms.

[42] WD004627
[43] WD006194
[44] WD007382, p.6

5.113 In their 1970 report, the Inspectors "*over-riding riding impression was of a group of hard working staff tackling a wide variety of statutory duties with warmth and understanding in their dealings with clients. They are close to the life of the community*". They identified three areas that needed to be *"tackled urgently"*. First was the need to introduce a defined departmental structure to assist CCOs "*to function effectively, to their full potential*". Secondly, staff unity was to be encouraged, "*to remedy the separateness which has resulted from the different patterns of growth in the two different arms of the service*" (this is a reference to field CCOs on the one hand, and residential care workers on the other). Thirdly, staff development and training were necessary "*to enable all to achieve the best possible standards of professional practice*". The extract concludes: "*This last is of considerable importance given the relatively small scale of the Department which despite its size has to meet just as wide a diversity of human need as a large organisation commanding greater specialist resource*."

5.114 The Inspectors recommended, as a *"first priority",* the appointment of two senior CCOs. One of the advantages of creating these new posts would be to "*institute and develop the more regular system of case reviews which was recommended in the previous inspector's report but which has not been adopted. This lack constitutes a real weakness in the functioning of the Department and contributes to the lack of cohesion between fieldworkers, family group homes and staff of Haut de La Garenne. The process of regular reviews (e.g. at minimum intervals of 6 months) will also make it possible for Senior CCOs to assess the need, possibilities and standards of particular forms of care – foster homes; lodgings; day care*." Among other recommendations made was "*a more professional development of the family group homes into small children's homes, and a possible later expansion in numbers*". As for training and staff development, the Inspectors recommended that staff development should consist of seminars and talks, an in-service study scheme for unqualified residential staff, organisation of a new part-time qualifying course for residential staff leading to certification and an in-service study scheme for unqualified CCOs.

5.115 Patricia Thornton resigned as CO in 1971. Charles Smith was appointed to the post in 1972, where he remained until 1984. He had been assistant CO since 1966. During his tenure, issues of concern included recruitment and qualifications of CCOs and the establishment of a Children's Policy Review Committee. Of concern too was the running and management of HDLG, especially in the late 1970s: there are a large number of memos between Jim Thomson (Superintendent at the Home from 1977) and Charles Smith relating to the management and oversight of HDLG, to the relationship between CCOs and staff at the Home and to the role of the CO in overseeing the staff and the Superintendent. As discussed elsewhere in the Report, Charles Smith also devoted time to promoting the idea of professional fostering. In 1979, he prepared a report on the staffing of children's services.[45] In the same year, the Education Committee approved the appointment of additional child care staff on the basis of "a very large increase in the workload of the Department".[46]

5.116 In 1981, Department of Health and Social Services (DHSS) Inspectors from the UK, David Lambert and Elizabeth Wilkinson, carried out an inspection of the "Children's Section".[47] Their 92-page report, to which frequent reference is made throughout this Report, considered the organisation, resource and policy of the Children's Section, the scope of fieldwork, caseload management and staff development. An Education Committee Working Party was set up to implement the report's recommendations. Among the recommendations was that HDLG be closed, provision for residential care reassessed and resources increased for preventative care.

5.117 Terry Strettle, a Senior Social Worker from London, succeeded Charles Smith in 1984. In April 1986, the Children's Section produced a handout intended as an introduction to the work of the Children's Section for other agencies. The CO is described as being responsible for "*the efficient functioning of the Child Care Service and the operation of the various children's homes maintained by the Education Committee*". The role of the Senior Child Care Officers

[45] WD006963
[46] WD006965
[47] WD007382

(SCCOs) is set out – including Brenda Chappell's responsibility "*for the management of the two group homes*". The text provides a factual summary of the Children's Section areas of responsibility, including residential care: as at April 1986, there were eight CCOs; there were 54 children in residential care in the "four children's homes": Dunluce at HDLG, La Preference and the two remaining FGHs, with a number of children placed at Brig-y-Don Voluntary Home: "*The Children's Section also approves, trains and supports foster parents in 70 foster homes. An average of 175 children are in the care of the Education Committee …* ".[48]

5.118 Later in the same year, Terry Strettle retired from his post, to be replaced by Anton Skinner. In an interview with the *Jersey Evening Post*, Terry Strettle reflected on his time as CO and on the social issues confronting the island.[49] He commented that his appointment by the Education Committee was a recognition that they had needed someone with wider experience to introduce the latest ideas from the UK "*that were appropriate to Jersey*". The Committee had realised that the *"the only way was to get someone from the UK"*. The article noted that an estimated one third of the Children's Office cases were related to alcohol. Terry Strettle was quoted as stating that "*child abuse is possibly not a cause for grave concern but there should not be complacency".* In order to cope with sexual abuse, "*seminars have been held and a number of childcare officers have been on courses in the UK*". He considered that there was a danger in Jersey of leaving a lot to voluntary effort and that more resources were needed. CCOs' caseloads remained heavier than recommended – 40 families, compared with the UK's 25–35.

5.119 The article noted that "*the one major change that Terry Strettle brought to Jersey was the concept of a move away from children in care to children in the community … living with their families*". Elsewhere in the interview, he is quoted as saying: "*In the UK there are many teenagers in the 13 to 15 age group in care either because they are in trouble, or have been playing truant,*

[48] WD006813
[49] WD00681

or are beyond the control of their parents. We seem to be very good at not producing that problem. Somewhere along the line we are getting things very right because that is not a very great pressure area."

5.120 Appointed CO in 1986, Anton Skinner was recruited from within the island. Concerns voiced by John Rodhouse, Director of Education, that Anton Skinner lacked the necessary experience and exposure meant that he was required to spend two years in the UK working in a Social Services Department before being able to take up the post of CO in 1986. Part of Terry Strettle's remit had been "*to train up a Jerseyman to take on the job*".[50]

5.121 The Inquiry heard detailed and sometimes complex evidence on the changes to the structure of Children's Services between the late 1980s and into the 2000s. Among other developments were the following:

- 1989 – Development of a multi-agency child protection approach.
- 1991 – Child Protection Guidelines issued.[51]
- 1995 – Children's Services moved from the aegis of the Education Committee to that of the HSS Committee.
- 1995 – Strategic policy review on children and families issued.[52]
- 2000 – Revised Child Protection Guidelines approved by Jersey Child Protection Committee (JCPC).
- 2001/2002 – Dr Kathie Bull's Reports: August 2001, "*Review of principles procedures and practices at Les Chênes*" and in December 2002, a "*Review of residential care homes and children with Emotional and Behavioural Difficulties and Disorders*".
- 2004 – Children's Executive established.

[50] WD006818
[51] WD009137: this was provided to the Inquiry in March 2016 and after the witnesses from Children's Services had given evidence
[52] WD005236

- 2005 – Change from committee to Ministerial Government.
- The *Children (Jersey) Law 2002* came into force.
- Publication of the Children's Executive strategic plan for 2006–2010.
- 2007 – Children's Executive minutes note that growth bids submitted in 2006 and 2007 were unsuccessful.
- 2008 – *An Inquiry into Child Protection*: Andrew Williamson.
- 2008 – Children's Executive progress report notes that the full range of development proposed by Dr Kathie Bull was not possible due to financial constraints.
- 2009 – Report on Staffing in Children's Services noted that staff were under considerable pressure.
- Williamson Report: Implementation Plan.
- Health, Social Security and Housing Scrutiny Panel publish *Co-ordination of Services for Vulnerable Children* (the "Breckon Report").
- 2011 – Report on "*Specialist Foster Care in Jersey*".
- 2012 – Action for Children: "*Review of Services for Children and Young People with complex and Additional needs".*
- Report of Scottish Care Inspectorate: "*States of Jersey – Inspection of Services for Looked After Children".*
- 2013 – Scottish Care Inspectorate "*Report of a follow-up inspection of services for looked after children in the States of Jersey*".

Child care officers: caseloads, supervision, training, visits

5.122 **David Castledine**[53] qualified as a social worker in 1967, working for a time in Leicester before taking up a post as a CCO in Jersey in 1974. When he started in 1974, he inherited a caseload of around 70 cases. Up to 1981–1982, he had his own caseload before being appointed Fostering Officer following a recommendation of the Lambert and Wilkinson Report. In 1996, he started working in the Long Care Team and in 1998 was made senior practitioner of the team. He retired in 2005. He told the Inquiry that, as far as he knew, all CCOs had professional qualifications in Jersey. Child care assistants (CCAs) were not qualified.[54] When he started in Jersey, the island had a higher proportion of children in care; CCOs appeared to have a higher caseload than he had had in Leicester. [55]

5.123 He remembered there being a rota among six CCOs, to cover out-of-hours work. The size of his caseload was not adjusted "*a great deal*" once he became Fostering Officer. There was no system for file allocation. The caseload was varied. Supervision of children in care was high on his priority list as a CCO. Private foster placements were not as high, due to manpower issues – children placed with private fosterer carers would be visited every three or four months.[56] He recalled that he did "*quite a lot of preventative work*" during the 1970s: there was an emphasis on preventative work from the Children's Officer. A number of his cases were not children in care, and those in care had home contact – some cases would be contacted two to three times per week.[57] From his own experience, he told the Inquiry that he did not think that the threshold for admission was lower than that in the UK. [58] Although he had received little training as a CCO, he did get supervision from an SCCO that was *'formalised'*, although it was less formalised than in Leicester, where he put in reports ahead of supervision. In Jersey, the tendency was to discuss particular cases; he recalled that he had sought to

[53] Day 85
[54] Day 85/14
[55] Day 85/15
[56] Day 85/20
[57] Day 85/22
[58] Day 85/25

introduce regularity of supervision from his experience in Leicester.[59] He remembered that he would give a case more input if there were relationship issues in the home. He would carry out regular visits, some unannounced, to check on the child's safety and when a child was initially placed in care he would visit at least weekly.[60]

5.124 From the outset of his time as a CCO, he remembers that he would speak to children alone. He would also speak to their carers to find out if any specific problems occurred, such as behavioural issues. When asked, he hoped that he had not been the exception in speaking to children alone. For his part, his contacts with allocated children were regular and always recorded. He remembers that they were given guidance on what they could or could not do. It was his recollection that, by the 1980s, CCOs stopped taking children out on their own because of the risks involved and child protection issues. Children would still be seen on their own but only in the setting the child was in, including their home. He told the Inquiry that this did "*limit options*". A CCO could take a child out, but this had to be in the presence of another colleague. He remembers there being an increasing awareness of safeguarding and risks to adult and child in the 1970s.[61] Specifically, on his visits to the FGH at Clos de Sables, he had spoken to the children on their own.[62]

5.125 He told the Inquiry that placement once the care order had been made would have been a matter of professional judgement on the part of the CCO. The suitability of a placement would be regularly reviewed. He recalled six-monthly reviews taking place at HDLG. He remembered that the reviews might say for the child to remain at HDLG as there was no other option available; discussions about placement would be recorded, but perhaps not on the six-monthly review form. Expediency was sometimes a factor in determining where a child was placed. HDLG was not invariably his least favoured choice: his memory was that some children had a positive experience there. It could

[59] Day 85/26
[60] Day 85/27–28
[61] Day 85/29–31
[62] Day 85/48

also be used in the short term to take a child away from a worse situation and to develop a case plan from there.

5.126 As CCO, it had not always been easy to build relationships with staff at HDLG because of shifts and the turn-over of staff at the Home. This was why he preferred fostering and smaller homes as placements. He would have separate days for visiting children at HDLG and would not visit his allocated cases all in one go. He would spend around half an hour with each child. There were sitting rooms where they would see children on their own.[63] He recalled discussing the use of detention rooms once or twice, as they had been used two or three times in a few weeks, and he wanted to know the reason; there was an occasion on which he disagreed with its use when he did not see it as being in the interests of a child: he had taken it up with senior staff at the Home. He recollected that children would complain to him about certain things.[64]

5.127 **Anton Skinner** was a CCO between 1973 and 1978 and then an SCCO between 1978 and 1986. In the later period he was seconded to Berkshire Social Services between 1982 and 1985, at the instigation of the Director of Education, John Rodhouse, who felt that Anton Skinner needed to gain more experience before taking up the role of CO (see above). He served as CO between 1986 and 1995. In his statement to the Inquiry[65] he provided an account of his time as a CCO, SCCO and CO. He described his caseloads as *"combined"*, encompassing vulnerable families, vetting foster parents and preparing court proceedings. There was no formal supervision – simply informal discussion with his SCCO. He remembers, as a CCO, "*around 360*" children in care – much of his caseload consisted of families from deprived and impoverished backgrounds. The frequency of visits to allocated children depended on stability of the placement: for example, those in FGHs or foster care were visited less frequently. If he had concerns about a child, they would be visited weekly; in his statement he remembered that he could go and see

[63] Day 85/52
[64] Day 85/57
[65] WS000614; Days 87–89

children allocated to him "*every so often … we had very little time to take them out one-to-one*"; there was no guidance when he was a CCO and SCCO as to how frequently a child was to be seen. Whether or not children were seen, there was, as Anton Skinner saw it, still regular contact with the homes through Children's Services.

5.128 As CCO, he would carry out six-monthly reviews for children in care, although he accepted (and as was identified in the Lambert and Wilkinson Report) there was no statutory basis prescribing the timing. The six-monthly reviews setting out limited planning options seen repeatedly in evidence by the Inquiry were a reflection, he said, of the "very" limited planning options available. He accepted that it was more difficult to work in a focused manner towards meeting a child's needs because the options were so limited. He challenged the suggestion that children "drifted" in care: in Jersey, large sibling groups came into care whose parents actively avoided re-assuming their responsibilities to their children. It was accepted that some children would spend long periods in residential child homes – "*there was effectively nothing they could do in that period*".[66]

5.129 He remembered that the Education Committee had little involvement in their work. It was the endorsing body for Children's Services. The Children's Sub-Committee had more involvement and would receive monthly reports from the Children's Officer.

5.130 As CO, Anton Skinner reported to the Director of Education, John Rodhouse, and subsequently to Brian Grady. He was responsible for all of Children's Services, including children in care, those needing assistance in the community, fostering and adoption and the investigation of complaints into neglect. He managed around 80 staff – 15 field staff – "qualified social workers" – and 30 to 40 residential staff. The Family Service Centre, started in the 1990s, had 10–12 staff. He would attend all CS-C meetings and keep them informed of developments, although there were times, he told the

[66] Day87/63

Inquiry, when confidentiality would mean that it was inappropriate to do so. He suggested that he consulted the Director of Education far less frequently than Charles Smith had done – "*he would be seen going down the corridor rather more often than the professionals viewed as necessary or indeed justified*". He was invited to comment on the Lambert and Wilkinson Report. The impetus at the time was to return a child to their home wherever possible. The Report assumed that, had there been a better review process, children would have returned home more frequently. Anton Skinner told the Inquiry that he did not think that this would have made a difference.

5.131 He remembered that, as at 1981, reviews involving all those involved in a child's care were "rare". He accepted that this was a deficiency in Children's Services at this point, although he qualified this by pointing to the smaller scale in Jersey and the fact that all the team, including the SCCOs, worked close by to one another in the same office: ". .. *you would be talking to your senior child care officer about the issues and problems and the latest issues with the family … and you were looking to work with a number of professionals to try and sort those things out*".[67]

5.132 Anton Skinner agreed with Lambert and Wilkinson's view that CCOs in Jersey were isolated and working out on a limb from UK practice: "*We did not have reciprocal arrangements in any great degree with the UK ... the main link was reading Social Work Today and going on courses.*"[68]

5.133 **Marnie Baudains**[69] was a residential CCO from September 1985 to January 1986. She then worked as a field Child Care Assistant then as a CCO from 1986 until 1993. She was a resource manager overseeing CCOs from April 1993 to January 1998. She was appointed Manager of Children's and Adult Social Services from 1999 to 2005, then Directorate Manager of Social Services from 2005 to 2011. She was a member of the Child Protection Team from 1989 and a member of the JCPC from its inception until 2010 (see

[67] Day 87/27
[68] Day 87/33
[69] Day 91; WS000618

below). She held a degree in social studies and a Master's degree in social work. She also held a CQSW. Prior to working as a CCO in Jersey, she had worked as a Residential Child Care Officer (RCCO) in an adolescent girls' home in Hounslow for a year, and then as a Deputy Officer in charge in an adolescent boys' home. When she first joined as CCO in 1986, there were between eight and 10 CCOs; her post as CCO was a newly created one rather than her replacing an existing CCO.

5.134 She remembers that when she started she had around 30 cases; the concept of protected caseloads had not yet been introduced. However, the build-up of her caseload was managed by her Manager – the Team Manager role existed in Jersey at the time of her appointment. Her caseload increased to about 40 after a short period and then stayed between 40 and 45 cases; one family could count as one case. When she started, existing CCOs were still carrying heavy caseloads. She put the reduction in caseload down to the gradual increase in the number of CCOs over time. She remembers that cases remained open because CCOs did not have enough time to close and write final summaries: "*there were piles of files waiting to be discussed and signed off.*" SCCOs would periodically review CCOs' files and give supervision but there was no formal policy – it was usually set at an agreed frequency by a manager. She recollected that when she started there was an informal understanding that children under 10 should be placed in foster care wherever possible; she thinks that this became formal policy at the time of the reorganisation of the Department around 1989–1990.

5.135 Planning meetings were held for children in care as part of the six-monthly review. She told the Inquiry that families and children were not involved in case conferences until the late 1980s. Questionnaires were introduced in the early 1990s to allow children to consider in advance issues that would be raised and to organise their thoughts. Planning for a child leaving care evolved "very slowly". There was a slowness in understanding the importance of helping young people in that transition as well as a lack of resources with only one CCO and a family support worker being allocated. Even in 2011, she

did not think it was in a healthy state. There was, she told the Inquiry, "*a much greater need than it was possible to meet*".

5.136 The planning for children in foster care was, she told the Inquiry, even more difficult: some foster parents found multi-professional forums strange and intrusive: they felt that they were under review, despite it being emphasised to them that the focus was on the child. She could not remember when but, at one stage, a dedicated CCO responsible for working directly with foster carers was appointed, alongside a separate CCO for the child. She thought that this had happened at some point in the 2000s. The new review process had not been audited. She told the Inquiry that she thought the new process had contributed to children remaining in care for shorter periods, alongside community-based support systems.

5.137 Marnie Baudains gave an account of the relationship between CCOs and key workers in the Homes. She said it was an *"important"* relationship. She remembered that the residential CCOs embraced key worker roles with some enthusiasm – "*it was a two-way street*"; she gave examples of how productive the shared management of the child could be; she felt that residential care workers had embraced the role with "*enthusiasm*"; "*this was a positive development in that it gave them a sense of personal responsibility for an individual in the home*".[70] She did not, however, see the role as replacing the existing responsibilities of the CCO.

5.138 She told the Inquiry that there was no regulatory inspection of care homes during her time as either a CCO or a Resource Manager – she was surprised that there was no way of establishing the quality of practice in a formal sense: she assumed that there were "*people who had responsibility as managers for the children's homes and … that that included a level of scrutiny as to the practices and quality of the home*".

5.139 She remembered that, initially, records for children would be maintained as family files recording contact, court reports, six-monthly reviews, case

[70] Day 91/20

conferences and memos. SCCOs would "*look at files on a fairly regular basis*" and would have to sign off on various documents and six-monthly reviews. Children's homes retained individual files on children. She may have seen them occasionally, but not routinely. These would have been separate from the CCO file on the child, although there would be a lot of duplication.

5.140 As for the destruction of records occurring at the time of Children's Services moving, she believed that there was a written protocol but she never saw a copy. She told the Inquiry that files were reduced to one document (a green sheet). She did not think that contact had been made with individuals before their files were filleted. She did not know the extent to which CCOs had offered children to go through their file when they reached their majority, although that was good practice; she herself had done so with her clients. In her view, it was clear that the decision to thin down files, taken for practical reasons, "*was extremely regrettable*", given the now-recognised need for those in care to revisit and understand their experiences. It was, she told the Inquiry, only relatively recently that people came to know that they have a right to access their files and want to do so. She thought that the decision had originally been taken in good faith but, based on what is known now, that was a mistaken presumption. By the time she had retired in 2011, there was a file retention system.

5.141 **Tony Le Sueur**[71] was a youth worker between 1978 and 1990, eventually running a Youth Centre. He then joined Children's Services. Between 1991 and 1995, he was a Senior RCCO at Heathfield. He was Officer in Charge at La Chasse between 1998 and 1999. Between 1999 and 2001, he was a Senior Manager in Children's Services (placement and support). He moved to adoption and fostering, where he worked between 2001 and 2004. Between 2004 and 2010, he was the Manager of Children's Services. In 2010, he was allocated to work as the Project Manager on the Williamson Implementation Plan. In 2012, he was appointed Policy Development, Governance and Quality Assurance Manager.

[71] Days 89,90 and 93

5.142 Tony Le Sueur remembers that key workers would contact CCOs to visit the children at the Home. His view was that the key worker filled in for the CCO with the heavy caseload and, as a consequence, children were not visited by CCOs as often as they should have been. He felt that professional social workers underestimated the impact their allocation to a particular child had and the importance of maintaining contact, while the key worker got *"very skilled"* at filling the gap left by the CCO. In response to suggestion that the role of the CCO was to hold the child throughout their time in care, Tony Le Sueur agreed, adding: "*I think at that point ... in social work that element was missing. It is why we moved to looked after children's procedures in the UK, it is why the UK moved to very structured looked after services that absolutely required the six weekly visiting … the looked after children's services have changed significantly in the time that I have been involved with the services … it is nothing like the same today as it was back then, but back then there were deficiencies and young people did suffer the consequences."*[72]

5.143 Tony Le Sueur did not think that, as at 1991, compared with a decade earlier, children were being taken into care to make caseloads more manageable; he felt that, by 1991, higher-risk situations, as he called them, were being managed in the community.[73]

5.144 **Pauline Vautier**[74] graduated with a degree in social sciences in 1978 and then worked in Children's Services between 1978 and 2009, first as a CCO until 1984, then as a volunteer at the Family Service Centre between 1984 and 1993. She then led social work assessments until 1999. Between 1999 and 2009, she worked as a CCO on the Child Protection Team until 2004, and then on the Leaving Care Team until 2009, when she left the service.

5.145 She described starting as a CCO in Jersey in 1978 as "*almost the beginning of social work in Jersey*"; she inherited an unprotected caseload of 60 cases, – "*60 families rather than 60 children*" – "*the expectation was that I would get*

[72] Day 90/25
[73] Day 90/26
[74] Day 85

up and running with that as quickly as possible"; initially she had informal supervision with an SCCO – later in her career, she had regular supervision and did training in supervision which was a three-day course by a trainer from England.[75]

5.146 She took issue with the Lambert and Wilkinson view that the availability of children's homes led to a tendency to use homes rather than use other options. She told the Inquiry that this was not the way that she would have worked. She would have initially looked for foster carers or small group placements rather than residential provision.[76]

5.147 She remembered that, as CCOs, they might not have visited children in settled care, given emergencies, but it was not the case that they did not visit at all. She did not think that this had an effect on planning for a child. It was, she said, still part of her role to make plans to reintegrate the child with their family. Although there were heavy caseloads, she did not remember this having the effect of lowering the threshold for reception into care. In the late 1970s, the decision was made through a dialogue between the CCO and their Manager.[77]

5.148 When Pauline Vautier left Children's Services in 1982, preventative services were not really developed, but the following years saw the beginnings of the Family Service Centre (mid-1980s).[78] When she returned to work in Children's Services she told the Inquiry that there had been a huge improvement in preventative services: "*it was a universal service*".[79]

5.149 Before the introduction of income support in Jersey in the 2000s, she saw as part of her role as a CCO the need to advocate for financial support for families before Parishes.[80] When she was a CCO there was no budget for young people leaving care, and it was difficult to access funds in the early days.

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[75] Day 85/159
[76] Day 85/160–161
[77] Day 85/165
[78] Day 85/166
[79] Day 85/167
[80] Day 85/172

5.150 By the end of her career, she told the Inquiry, there was a "*much, much greater emphasis on training*": there was a training officer and a person responsible for child protection training.[81]

5.151 **Dorothy Inglis**[82] qualified as a social worker in 1977 and then worked for Durham Social Services. She applied for a CCO job in Jersey in 1979. When she started, her caseload was three times that she had experienced in the UK. Large caseloads were made more manageable, but she had far less travel time. In contrast to Pauline Vautier, Dorothy Inglis did find that children were taken into care in Jersey to help the family financially; in the UK, the welfare state provided the financial support. There was a demarcation between residential and field workers: she told the Inquiry that it would have worked better had each had a better understanding of the other's role. She remembers that it was not easy to plan for children placed at HDLG because the CCOs were concerned not to appear critical of residential staff. There was, she thought, a better working relationship between CCOs and the staff at Heathfield and La Preference. She found the idea of "working together" in Jersey was better than in the UK because she developed closer working relationships with other professionals as it was smaller and she would see other professionals on a regular basis. She remembers there being training but that it was much better for field workers than residential staff. She had been formally supervised in the UK, whereas in Jersey she was not – she agreed with the Lambert and Wilkinson Report that the system of supervision in Jersey left too much to the CCO and human error. She also thought it a fair criticism that the lack of a satisfactory review system may have contributed to children remaining in care too long. She told the Inquiry that, by the late 1990s or the 2000s, the position was very different and the review system was far more rigorous. She did think that children had "drifted" in the system because of the poor review process, but there was also a lack of resource to carry out a particular plan for a child.

[81] Day 85/183
[82] Day 97

5.152 **Danny Wherry**[83] When he started as a child care assistant CCA in 1981, he worked in a team of 12, most of whom were from the UK. He applied for the post of CCO in 1988 and was successful. There were no written policies or guidelines. Given the scale of Jersey, he did not think it was necessary to have any policy or guidelines. It was very much up to the individual to get their own training. He did not think that Children's Services should have provided more resource for training.[84]

5.153 He had started with a caseload of about 30 files. He would not record all of his visits when seeing children for whom he was responsible – only what he called "pertinent" visits. He explained what would qualify for a record being made. He would try to see children assigned to him once a month, but it was at his discretion. He remembers that Senior Social Workers would review his caseload.[85] Formal supervision, he remembered, came in the mid-1980s.

5.154 He remembers that, as a CCO, he was first encouraged to see children on their own in the late 1980s "*when child protection came to the fore*". He told the Inquiry that he was not particularly concerned by the length of time for which children were in care compared with his experience on secondment in New Zealand in 1984.

5.155 **Marilyn Carre**[86] worked as a CCA from 1977 to 1988 and as a CCO from 1988 to 1990. Initially, she worked as a field worker, visiting families and children. In 1988, she qualified with a CQSW. For a period after she qualified, she had a protected caseload and was supervised by Dorothy Inglis, although she told the Inquiry that this more akin to mentoring.[87] She described starting as "*hitting the ground running*". She had worked primarily in the intake team, taking calls from the Police and members of the public relating to child welfare. She remembered that when a child was referred to Children's Services the case would be discussed at team allocation meetings and a member of the CCO staff would be allocated the file by the Line Manager.

[83] Day 67
[84] Day 67/38–40
[85] Day 67/ 25
[86] Day 81
[87] Day 81/90

Each member of the team had certain specialisms. On the whole, training was poor and, she felt, left practitioners ill equipped. It was ad hoc and she thinks it was optional.[88] When she worked as a CCO, no-one was specifically responsible for training – there was no training officer.[89] She remembers that field workers were overstretched, with too big a caseload. Because even the managers were stretched, supervision was not as regular as it should have been. She did not remember being followed up with any stringency. When she moved to the Probation Service she found that supervision was extremely thorough. She had felt much more supported when working for the Probation Service.[90]

5.156 **Richard Davenport** was appointed a CCO in 1971. He had obtained an extra-mural certificate course in social studies from Leicester University in 1970 following a three-year course. In a statement to the police in 2009, he remembered that when he started as a CCO "*we had to deal with a massive case load, which today would be totally unacceptable … I wrote everything down in those days, perhaps in too much detail as far as some line managers were concerned*".[91] As a CCO, his name appears frequently in the records of those in the care of Children's Services over the next 20 years. By way of example, he was the allocated CCO for a number of children placed in the Blanche Pierre FGH.[92] In March 1996, a record was made, summarising what appears to have been formalised supervision sessions that Richard Davenport had had "*in the presence of Anne Herrod SCCO*". The file note refers to an "*exercise in culture audit*" being carried out and complaints from staff concerning Richard Davenport's behaviours and attitudes, as well as concerns "*expressed during recent years concerning his performance as a CCO*", "*[he] was left in no doubt that his performance had to improve in all areas detailed if he was to remain a member of the child care staff … methods of improving performance were discussed and outlined for Mr*

[88] Day 81/8
[89] Day 81/81
[90] Day 81/92
[91] WD006859
[92] WD000579

Davenport and he was made aware that any future complaints would be dealt with through the agreed disciplinary procedure".[93]

5.157 **Hal Coomer** was a CCO between 1975 and 1990. His principal focus was on families in the community. He was also responsible for a number of children in children's homes, whom he would visit approximately once a month. Several of his allocated cases were at HDLG, although he had never had more than two children there at any one time.

5.158 **David Dallain** was a CCO between 1982 and 2002. On starting, he was given a caseload of 10 children to supervise: "*Each child would have been assessed* as bei*ng in need of supervision and be either under a care order or in voluntary care … I would visit them at regular periods to assess their welfare. The regularity of the visits would depend on their circumstances and age although there were firm guidelines for how often children in foster homes should be visited.*"

Child protection/training: handling disclosure

5.159 Prior to the establishment of a Child Protection Team in 1989, Anton Skinner described "*the usual tensions between Children's Services and the Police over child abuse referrals. The police considered that social workers unwittingly undermined their investigations".*[94] Children's Services thought the police used heavy-handed tactics during investigations, causing further damage to the child.

5.160 The creation of a joint investigative team in 1989 "*removed those tensions*", in Anton Skinner's view. Any referral of potential abuse received by Children's Services was considered jointly with the SOJP.[95] Anton Skinner considered that the Child Protection Team: "*worked like a dream*"; the benefit was that the agencies worked together: "*for the first time everyone was well trained and well equipped to deal with issues of child abuse*." He told the Inquiry:

[93] WD006821
[94] WS000614/24
[95] Day 87/165

"*Generally the police would manage the process of prosecution … I do not personally recall any serious allegation of physical or sexual abuse relating to children in residential care homes or foster care being made or reported to Children's Services which did not go through this process.*"[96] He told the Inquiry that it was "*accepted practice*" that referrals would be made automatically to the Child Protection Team.[97]

5.161 The pool of staff involved comprised two Police officers and three CCOs. The original team of CCOs consisted of Marnie Baudains, Dorothy Inglis and Martha Pugsley. The aim was to provide a co-ordinated, skilled and prompt response to disclosures to ensure the safety of the child and to gather evidence; joint investigation procedures were agreed at the outset. A policy booklet was developed in the early 1990s.[98] Joint training in interview techniques was provided and specialist training on a multi-agency basis. Madge Bray of the Sexual Abuse Child Consultancy Service provided training on responses and therapeutic care. Ray Wyre provided training on techniques to assist a child to disclose abuse. In the early 1990s, a multi-agency working party was set up to review aspects of child abuse and the law, and specifically corroboration and the giving of evidence.

5.162 Marnie Baudains told the Inquiry that the number of referrals grew each year, due to the increasing skill and understanding of the team members about child abuse. As the number of investigations grew, so too did the ratio of successful prosecutions.

5.163 An article in the *Jersey Evening Post* in February 1990 reported the increase in reported cases of abuse and the establishment in the previous year of "*a new child abuse team of specialist officers from the Children's Department and the States police … to investigate cases of suspected child abuse…its*

[96] WS000614/25
[97] Day 87/165
[98] WD009137

aim is to protect the abused child and the officers have undertaken specialised training courses in this area of work."[99]

Relationship: Children's Services and the Police

5.164 Marnie Baudains told the Inquiry that, from 1993 to 1999, the Child Protection Team met on a weekly basis to review current cases and plan joint action. All Child Protection Team members received joint training in interviewing techniques.

5.165 Marnie Baudains reflected that the number of successful prosecutions still remained relatively low, driving her to take a team to the UK to see how court arrangements could be improved for vulnerable witnesses. In 1993, she was appointed Resource Manager in Children's Services, with responsibility for the Child Protection Team. In her view, close working relationships between Police and CCOs in the Child Protection Team became *"well established"*.

5.166 Marnie Baudains thought that there was a lack of expertise in the Police team in 2006–2008, exacerbated by DI Alison Fossey's absence while on training. In 2006, DI Alison Fossey had been appointed to the SOJP's Family Protection Unit.

5.167 The relationship was affected, according to Marnie Baudains, by the introduction of the *Children (Jersey) Law 2002*. A care order under the new legislation required, she said, a higher evidential burden to show that a child was at risk of substantial harm. Thus, before applying for an order there was an obligation to consider all other options to keep the child safe, and a detailed care plan had to be formulated, showing that taking a child into care would substantially improve their circumstances. Marnie Baudains did not think that these changes were properly conveyed to officers on the ground. This led to frustration with Children's Services rather than the new environment in which both agencies had to work. Under the new law, two orders were introduced where a child was at imminent risk: a Police protection

[99] WD006816

order (PPO) and an emergency protection order (EPO). Marnie Baudains told the Inquiry that she felt that the Police appeared to be reticent about using a PPO, which was a quicker and less complicated order to obtain. Her impression was that the police thought that Children Services were reticent about using EPOs.

5.168 Marnie Baudains told the Inquiry that the Police and Children's Services had different thresholds, priorities and constraints and this led to some tension between the two bodies. In her view, the Police tended to be more comfortable in an investigation environment that involved response and resolution. Children's Services were sometimes frustrated by the lack of Police understanding of the complexities of removing a child into care, in terms of both the potentially negative impact on the child and the challenges of the court process. The Police had a better relationship with the Assessment and Child Protection Team than the Long Term Team because they worked with them more regularly; she said that it was misconception that if the phrase "child protection" was not used, nothing was then being done to help the child. She felt that that ignored the fact that children are being protected and supported every day.

5.169 These tensions were reflected in the exchange of evidence on child protection cases conferences between Daniel Wherry and DI Alison Fossey (see below). Marnie Baudains felt that this exchange demonstrated a misunderstanding between a child protection conference and normal case conferences. It would, she said, have been entirely inappropriate to have registered a child at a case conference that was not a child protection conference. This was not a bureaucratic nicety: the requirement was enshrined in multi-agency procedures and allowed, in her view, for proper safeguards.

Child Protection Committee

5.170 In the mid-1990s, a steering group was established to bring into being the JCPC; modelled on area child protection committees in England and Wales, it was intended to support the development of multi-agency working and raise awareness of child abuse and how to respond to it. The Chair of the

Committee was to be independent of the agencies represented on the committee. This contrasted with many Area Child Protection Committees in England and Wales, where the Chair was often the Director of Social Services. Unlike Child Protection Committees in the UK, the JCPC had no statutory authority. It had no core funding.

5.171 The first Chair, Jurat Maizel Le Ruez, established comprehensive multi-agency procedures as well as a training programme, and secured an initial budget in 2000 for a multi-agency Child Protection Training Co-ordinator. The co-ordinator was to be supervised by the Manager of the Children's Services Child Protection Team. The next chair of the JCPC was Iris Le Feuvre, a long-standing senior politician. In Marnie Baudains' view she was respected in the community and had maintained a continuing interest in the welfare of children. She had been president of the Education Committee.[100]

5.172 Child Protection guidelines were updated and published in 2006 and in 2011. They appear to us to have had little impact on the quality of social work practice. We come to this conclusion in the light of the evidence we heard and read from several witnesses including Daniel Wherry, Pauline Vautier, DI Alison Fossey and Janet Brotherton.

5.173 Pauline Vautier had had to deal with disclosures of abuse later in her career, when on the Child Protection Team, and felt adequately supported in this – they would meet regularly to share experiences and would meet with counterparts in the Police.[101] She had been surprised by the Education Committee turning down a recommendation from Lambert and Wilkinson that "*senior staff of all agencies should meet to consider policy and to consider greater co-ordination of services, monitor the incidence of abuse and consider the training needs of staff".*[102] She felt that there seemed to be a contradiction between what was said and what was actually happening. She had no idea

[100] WS000618/p.55ff
[101] Day 85/185
[102] WD007382/38

what the reluctance was and did not know whether the reluctance was due to a lack of political will or was resource driven.[103]

5.174 Daniel Wherry was in a team of four with Marnie Baudains, Jean Andrews and Dorothy Inglis, and all referrals of abuse came to them. He remembered having "*quite substantial training in child protection particularly regarding interviewing children*".[104] He said that practice was drawn on UK approaches. He described a poor working relationship with the Police from 2006: the Police sought at that point to undermine the work of Children's Services. His view was that the Police *"only wanted convictions whilst the Children's Services wanted to always put the needs of the child first"*.[105] He disputed the suggestion by the Police that Children's Services would encourage parents to make complaints against the Police so as to discourage Police involvement in cases involving children: "*This was absolutely not the case for me and I've never heard anyone in the Children's Services express this view*."[106]

5.175 Janet Brotherton attended a child protection conference in 2002 chaired by Daniel Wherry. She told the Inquiry that she was *"speechless"* when he opened the conference by stating that names were to be removed from the Child Protection Register and that they *"do not bother"* with reports *"here"*.[107] She did not take the matter any further at that time.

5.176 Daniel Wherry was invited to comment on a series of memos prepared by Bridget Shaw (Legal Adviser, Law Officers' Department) and DI Alison Fossey, critical of his handling of case conferences.[108] In a series of forceful rejoinders he described the criticisms as *"absolute nonsense"*. We were not persuaded by his denials.

[103] Day 85/188
[104] Day 67/75
[105] Day 67/83
[106] WS000543/17
[107] Day 86/79
[108] WD005327; Day 67

5.177 The "At Risk Register" was introduced in Jersey in the late 1980s. Phil Dennett suggested that Jersey was only then "catching up" with the UK.[109]

5.178 Janet Brotherton[110] had a Master's degree and other qualifications in child protection. Before coming to Jersey, she had worked as a specialist nurse in child protection in an NHS Trust. She had had responsibility for ensuring implementation of policies and procedures. She had regularly provided training. In 2002, she took up the post of Multi-agency Child Protection Trainer for the JCPC. Her evidence to the Inquiry, which we set out in detail below, focused on what she found in Jersey when she started in 2002, the changes in training she established and the agencies' response to her training. We found that her evidence provided an "outsider's" perspective on aspects of Children's Services approach and attitudes at the time.

5.179 She said that the child protection training provided by Daniel Wherry was badly presented, out of touch and behind the times – she found it to be *"completely outside my experience. It was poor"*. She said that there was no structure to the training and that he did not appear to have an understanding of child protection issues. During her first week in post, and because of her concerns, she spoke to Sarah Brace, Manager, Assessment and Child Protection Teams. She was told that Daniel Wherry would no longer provide training and that henceforth training was her responsibility.[111]

5.180 Janet Brotherton said that the lack of multi-agency policies and procedures in Jersey was a weakness. It made it difficult for anyone to challenge poor or inappropriate working practices.[112]

5.181 Aside from her view of the quality of the training provided by Daniel Wherry, the other impression Janet Brotherton gained that suggested to her that Jersey was behind the UK in child protection was the absence of systems. Jersey did not have anything similar to "Working Together", which followed

[109] WS000628/18
[110] Day 86
[111] Day 86/11
[112] WS000610

the *Children Act 1989*; training was not available at the same level as in the UK. Jersey was not a multi-agency forum and there were no sub-committees.[113]

5.182 In February 2011, island-wide multi-agency policies and procedures were implemented. Janet Brotherton's recollection was that multi-agency procedures were being introduced in the UK from 1992.

5.183 In January 2008, Professor June Thoburn, a highly respected and experienced UK academic, was appointed Chair of the JCPC. Janet Brotherton described her appointment as *"pivotal"*, a *"breath of fresh air"*.[114] Under her tenure there were what Janet Brotherton described as *"key developments"*. One was the recruitment and training of an Independent Board of Visitors for the children's homes; another was the introduction of an extended Child Protection Training Programme; and a third was the expansion of the multi-agency training pool. The period also the publication of Jersey's first SCR.[115]

5.184 Janet Brotherton was given an annual budget of £5,000 to arrange all training. She managed on the budget, she said, by being inventive. The budget for training increased in 2009, when Mike Taylor became Chair of the JCPC. Children's services managers did not attend training on child protection, and the Long Term Team did so rarely. She suggested that staffing may have been an issue, as they were short staffed, and that there may have been misconceptions as to the suitability of the training – that it was at a low entry level. The Family Support Team, by contrast, attended every session. The residential services had a "slow start" but, she said, came to value the training.

5.185 Janet Brotherton said she had great expectations for the Williamson Report (Inquiry into Child Protection in Jersey, June 2008) but was disappointed when it failed to address, in her view, concerns about child protection. There

[113] Day 86/17
[114] Day 88/35
[115] WS000610/8

was no reference within the report to the prevalence and scale of child abuse in the home or the anxieties surrounding certain cases: "*it would have been very useful to have information about what was actually happening, number of referrals, types of abuse, how many children in need … how many children on the Child Protection Register*".[116]

Structural and management changes

5.186 Marnie Baudains told the Inquiry that, in 1988, the CCOs' fieldwork was restructured, with a greater emphasis on support in the community and preventative measures.[117] An "Under 5s Team" was established, focusing on early intervention. Marnie Baudains became part of that team. Prior to the changes, a child at risk would have been removed for a short period or even permanently. The consequence of the restructure allowed the CCO to ask what they could do to help the family and increase family support to improve the child's circumstances in the home.

5.187 A residential family centre opened at La Chasse, providing bedsits and flats for young mothers and children.

5.188 The new structuring envisaged helping parents engage with schools as well as looking at family support as a whole. In the first of two statements to the Inquiry, Marnie Baudains reflected that:

> "*The main aim of the preventative policy was to look at the family as a whole and to identify ways to support them within their own community and social networks by utilising mainstream and specialist services in a planned and coordinated way. The key characteristics of the preventative policy were assessment, planning and delivering support, monitoring and re-assessing.*"[118]

5.189 Restructuring also led to the formation of an "Intake Team" – which primarily undertook short-term work, identifying needs and implementing plans over the short term in tandem with other agencies within Children's Services. An adolescent team, based at Heathfield, was created, its aim being to respond

[116] Day 86/79
[117] WS000618
[118] WS000618

to the needs of adolescents at risk of reception into care. The team was run initially by Geoff Spencer and then jointly managed by Phil Dennett and Mary Finn.

5.190 The main reason for the changes, Marnie Baudains told the Inquiry, was to try to ensure that children were nurtured within their own family or, if that was not possible, then within a foster family or a small residential home.[119]

5.191 Phil Dennett qualified as a social worker in 1984, obtaining a CQSW. He had previously worked in two children's homes. On qualifying, he worked for three years as a social worker in Bristol. He moved to Jersey in 1989 to become an SCCO at Heathfield. Once there, he was asked to manage the preventative community work centre as part of the adolescent team.

5.192 His first impression when he started was that the threshold for children being received into care in Jersey was "*too low*" and that "*the high numbers of children in care in Jersey was largely the result of a much wider social policy issue … the number of children in care ultimately comes down to how society responds to its young people, and what society considers to be acceptable"*.[120] There was, he said, "*an intolerance to young people*" in Jersey at that time. This was shown not simply by receptions into care, "*but the way young people were pushed towards the criminal justice system*", and the way it would have been reported in the press. By the time he left Children's Services in 2014, he felt that the attitude had improved – "*Jersey society may be a little more understanding of young people*" – but he considered that Jersey still needed to look at how it deals with "*its most vulnerable population".*[121]

5.193 Phil Dennett told the Inquiry that when he started with the preventative centre at Heathfield he was "*staggered*" by the amount of money given to the project: "*the funding was there when we needed it*". No qualitative assessment of the preventative centre work was carried out by Children's Services – there was no system in place for monitoring outcome for children. In later years, as

[119] WS000618, paragraphs 63–64
[120] Day 95/21
[121] Day 95/23

Children's Services came under the umbrella of Health and Social Services, funding became much tighter as Children's Services competed with health provision.

5.194 In 1996, Children's Services transferred from the Education Committee to the Health and Social Services Committee. The proposal of a separate Social Services Committee had been rejected by the States.

5.195 HSS comprised hospital services on the one hand and a Directorate of community-based health, mental health and social care services – this was led by Anton Skinner, who became Director of Community and Social Services.

5.196 In February 1997, Bob Woods became Acting Head of Children's Services; his remit was to integrate the adult social service team with Children's Services. In March 1998, Marnie Baudains took over the role as Acting Manager for Children's Services and retained responsibility as Manager of the Child Protection Team. In her view, during this period Children's Services were "*stretched*".[122] She told the Inquiry that the integration of Children's Services into HSS was "*complex*".

5.197 In June 1998, Phil Dennett left Heathfield and became Acting Resource Manager for Residential and Respite Services, giving him responsibility for overseeing all of residential provision for children, including Heathfield and La Preference. He described this period as a "*very difficult and turbulent transition for Children's Services".*[123]

5.198 In September 1998, Bob Woods died. His death as the effective Head of Children's Services was a "*profound blow*". Marnie Baudains described his loss as leaving Children's Services "*very exposed*".[124] By December 1998, Children's Services was being managed by Marnie Baudains and Phil Dennett.

[122] WS000618
[123] WS000628/20
[124] WS000618/53

5.199 In early 1999, Marnie Baudains became Manager of Children's and Adult Social Services. Phil Dennett was appointed Service Manager of Children's Services, reporting to Marnie Baudains. He described this period as "*firefighting*".[125]

5.200 In October 1999, three team managers were appointed within Children's Services: Tony Le Sueur, Manager of Placement and Support, Sarah Brace, Manager of the Assessment and Child Protection Teams and Sue Richardson, Manager of the Long-Term Team. Phil Dennett described in his statement the difficulty of recruiting externally, echoing earlier passages in this Report about the high cost of living in Jersey and only rental accommodation being available. In March 2001, Tony Le Sueur moved to the newly created post of Team Manager for Adoption and Fostering. Marnie Baudains said that the post was created in recognition of the need for robust oversight and development of fostering and adoption services.

5.201 Phil Dennett said that the Children's Services' move to the Health and Social Services Department "*did not make it any stronger than it had been under the Education Department. We still struggled to achieve adequate support and scrutiny at a ministerial level".* He told the Inquiry that senior managers in Children's Services "*all knew that we needed significant investment. We knew that there were voids in the service, but without the necessary resources it was impossible for us to grow into a modern service of the likes of the UK*".

5.202 Phil Dennett also highlighted the practical effect on Children's Services of the system of government in Jersey: "*Our political positioning was not the only stumbling block to our development. The fact that Jersey has no central government meant that any policy changes had to come from within the service – from drafting through to implementation. We were therefore having to find additional time to do this ourselves, which generated further pressure upon us to develop policies and procedures. However, we were doing this*

[125] WS000628/21

without the support of politicians with experience in the area of child care who could help drive the necessary policies and legislation forward."[126]

5.203 Richard Jouault worked in Jersey as a speech therapist from 1995 to 2003. In 1998, he obtained an MBA and in 2003 was appointed Manager of Rehabilitation and Services for Older People. In 2004, he became Director of Corporate Planning and Performance. In evidence to the Inquiry, he accepted that, as at 2004, he had "*very limited*" experience of Children's Services and no social work experience. In his statement to the Inquiry he explained that the Children's Executive sought to bring together all services responsible for children. Phil Dennett was appointed Co-ordinator of the Children's Executive. Richard Jouault had limited involvement with the corporate parent, whose function was to deliver child-oriented policy.

5.204 Richard Jouault was appointed Deputy Chief Executive of the HSSD in 2007; his remit included staff disciplinary investigations. His role in in 2008 was to work with Andrew Williamson, who had been commissioned in 2007 to review child protection in the island. In 2009 he was appointed Acting Chief Executive of Health and Social Services. The Child Policy Group was set up in 2010 (in place of the corporate parent). The corporate parent and its successor was made up of the three Presidents (later Ministers) of the Education, Health and Social Services and Home Affairs Committees (later Ministries). He was responsible for setting up a project team and providing costings for implementation of the Williamson Report. The project team was Phil Dennett, Marnie Baudains, Tony Le Sueur and Mario Lundy.

5.205 In 2012, Richard Jouault became Managing Director of Child and Social Services and oversaw the publication of the Scottish Care Inspectorate report. He remained within the Health and Social Services Department until September 2014.

5.206 Tony Le Sueur told the Inquiry that, in 2010–2011, there was a restructure of Community and Social Services into three directorate positions. There was,

[126] WS000628/28

he says, a lack of competition in senior staff positions which he felt led to a lack of stability, as those appointments that were made were on a temporary basis.

Multi-agency working

5.207 Multi-agency working took some time to develop, said Marnie Baudains. There was no formal sign-up to agreed multi-agency procedure occurred until 2001 but co-operation between services had been on-going since the early 1990s. A comprehensive Children's Service Child Protection Policy and Procedure had been in place for some time. This was subsequently updated to form the core of the multi-agency procedures (2000/2001).

5.208 Some professionals, such as doctors, were uncomfortable initially about the sharing of information. In the early stages, there were issues with some health visitors and GPs regarding fees. Some were prepared to waive fees for vulnerable families; others were not prepared to engage.

5.209 Marnie Baudains told the Inquiry that a constant issue was the need for independence and consistency in chairing child protection conferences. It was not until 2005 that a limited budget was made available for the appointment of Jean Andrews as Chair. This appointment, she said, was not "*perfect*" because as a retired Child Care Officer Jean Andrews was perceived to be inextricably linked to Children's Services.

5.210 When Pauline Vautier returned to Children's Services in 1999, the beginning of multi-agency work was being established, but, much more recently, the idea of corporate responsibility and multi-agency working has "*robustly*" come in: "… *certainly it would seem to me that was the beginning of a more cohesive multi-agency approach which then has been – with the bringing in of the assessment framework in England and other agencies signing up to multi-agency work … that has rolled out sort of more and more*".[127]

[127] Day 85/186

5.211 In his statement to the Inquiry, Phil Dennett reflected that some agencies "*were unsympathetic to the challenges and difficulties that residential staff and Social Workers faced when dealing with challenging and complex children. For example, probation staff and the police officers were occasionally critical of the fact that we were not keeping some of the children in care 'under control' - which was how they saw it".*[128]

5.212 The time it took to develop multi-agency working may have been reflected in the time taken for specific child expertise to develop in Jersey. For example, one significant development was the appointment in the late 1990s of the first Consultant Child and Adolescent Psychiatrist in the Island – Dr Carolyn Coverley. In 2005/2006, the first Consultant Community Paediatrician was appointed in Jersey.

Modernisation: politics policy and legislation

5.213 Pauline Vautier told the Inquiry that lack of policy was not something that struck her in 1978, but it did in later years when there still were not robust policies and guidelines. Most of her colleagues would have agreed with the need for them, but they took a long time to come in.[129]

5.214 Marnie Baudains told the Inquiry that when the *Children (Jersey) Law 2002* finally came into force in 2005, practical guidelines were not provided and there was little training; what training there was was provided by lawyers. Although advice had been available from the Law Officers' Department, she felt that Children's Services would have benefited from having in-house legal advice. She had hoped that the paramountcy principle enshrined in the UK's *Children Act 1989* would be prioritised but it was not in the Jersey legislation as it was in the UK. She thinks that the lack of a paramountcy principle may have had a consequence in the lack of political will for change within Children's Services.

[128] WS000628/29
[129] Day 85/175

5.215 When the *Children (Jersey) Law 2002* came into force in 2005, no additional resources were provided to Children's Services. She did not think that politicians appreciated the importance of the *Children Law 2002*; this, she felt, was a reflection of the lack of interest in Children's Services. The evident lack of political will was partly due to Children's Services being within HSS and health being such an all-consuming concern for many.

Structure and management

5.216 John Rodhouse (Director of Education, 1973–1986)[130] said that, while he was Director, resources were not a problem. He said that there were no circumstances in which he would go back to the States and request more money for Children's Services.

5.217 John Rodhouse did not think that the Education Committee undervalued the work of Children's Services, and recalled that committee members recognised the status of professional staff. He never claimed to have experience in social work but his view was that (knowing how the Education Committee worked) Children's Services would just have grown without any very clear plan of what it should do. Many of its "weaknesses", as he described them, were as a result of Children's Services history and the fact that it developed in isolation from the UK.

5.218 In Jersey, the number of social workers was quite small, and John Rodhouse said that this required people to have a range of skills that were not developed to the extent that they would have been in a larger organisation.[131]

5.219 John Rodhouse believed that agencies agreeing a course of action but not adhering to it held Jersey back considerably. He found this frustrating and wondered what might have been achieved if they had worked as a single organisation. He did not have concerns relating to training for those in Children's Services: they were professionally qualified and there was a

[130] Day 92; Day 95
[131] Day 95/192

training budget. It was never represented to him that training was inadequate.[132]

5.220 John Rodhouse disagreed with Anton Skinner succeeding Charles Smith as CO, as Anton Skinner had no experience outside Jersey. John Rodhouse said that he wanted the post advertised nationally but there were problems with the Housing Committee. It was agreed, therefore, that Anton Skinner would gain experience in the UK and Terry Strettle would act as a locum CO. [133] John Rodhouse said that his impression of Terry Strettle was a very positive one. It had been suggested to him that Anton Skinner should be appointed without any formal recruitment process: the emphasis was on restricting incomes, particularly in the public services

5.221 Frequent reference has already been made to the evidence of Tony Le Sueur. Immediately prior to the start of the Inquiry he held the post of Policy, Development, Governance and Quality Assurance Manager (2012–2014). At an early stage of the Inquiry he was seconded to be Programme Associate on behalf of the HSSD, as part of the States of Jersey Inquiry team. The appointment is not one related to the Independent Jersey Care Inquiry.

5.222 Tony Le Sueur gave evidence on Day 4 of the Inquiry about the history of Children's Services in Jersey since 1945. In the second tranche of his evidence (Day 89), he gave evidence about his own career, the impact on Children's Services of various reports and the organisational changes in Children's Services.

5.223 In the course of his evidence, he made some general observations on different issues:

- the JCPC became effective only once an independent Chair was appointed;

[132] Day 95/201
[133] Day 95/202–203

- the HR structures and organisation were not well attuned to handling complaints;

- he agreed that, with Children's Services, a high amount of responsibility rested with relatively few individuals, going on to add that politicians viewed Children's Services as well resourced;

- the first time that a training officer was employed in Children's Services was after the 2008 Williamson Report. Until 2010, post-qualification training had not been delivered "*in a structured way*". Training budgets were often a source for cuts, as cutting training had an intangible effect. By contrast, his recollection was that training had been provided for the implementation of the *Children (Jersey) Law 2002*;

- as at 2015, Tony Le Sueur was concerned at the continuing lack of accountability for the delivery of services to children in need;

- he was not hopeful that recommendations would be funded: *"we have played this game of external inspection ... identified resource requirement gets cut back to what can be afforded and you just keep going down the line".* Politicians need to understand that vulnerable children require support;

- Tony Le Sueur saw himself as a possible example of someone with insufficient qualifications being put in a managerial role. He was never given the opportunity to train off island.

Reports on Children's Services

Dr Kathie Bull's Reports (2000/2002)

5.224 Dr Kathie Bull, a UK Ofsted inspector, prepared three reports. The first report – into Les Chênes – is dealt with elsewhere in this Report.

Review of the Principles, Practices and Provision for Children and Young People with EBD in the island of Jersey (2002)

5.225 Marnie Baudains said that when the second report was published in 2002, *"there was not a co-ordinated care and support service to provide for [young children with social emotional and behavioural difficulties across service boundaries".*[134]

Outcome of action group deliberations (2003)

5.226 The final report, published in 2003, included proposals for improved residential and fostering services, the setting up of a dedicated secure facility, the setting up of a YAT and new accountability and management structures aimed at achieving better co-ordinated services. The budget to implement the recommendations in full was just above £3 million. The States allocated just over £900,000. It was therefore necessary, said Marnie Baudains, to reassess priorities and for some recommendations to be "*shelved altogether*" and others delayed. One example of delay related to fostering for which funding was achieved over a period of five or six years.

5.227 In 2004, the Children's Executive Board was formed, following the recommendation that all support and residential services for young people should be combined under one management structure. The Board was made up of the Prison Governor, a senior police officer, the Children's Services Manager, a Senior Manager from Education and the Deputy Chief Probation Officer. The remit of the Board was to increase the co-ordination of services and to ensure joint planning. Political responsibility and oversight rested with the corporate parent. As mentioned above, this comprised the President/Ministers of Health and Social Services, Education and Home Affairs. They met periodically, supported by the Chief Executive Officers/Directors of their respective departments. In Marnie Baudains' view, the new management structure (with the HSSD having eight directorates) led to the diminution of the voice of Community and Social Services.

[134] WS000618/59

5.228 For Tony Le Sueur, there was an element of disbelief when the Bull Report proposals were not implemented. He described the frustration of the Children's Executive reporting to the corporate parent, which, in turn, was "*ineffective*"; there was no commitment to work together and avoid the "*silo mentality*". He suggested, in evidence to the Panel, that the second and third Bull Reports were seen misguidedly to have evolved from the first report of Les Chênes. Other departments, in his view, thought that Education "*hadn't run Les Chênes properly … the other parties had been persuaded to move to this wider review when actually it wasn't required in the first place and therefore when we came out of it with a Children's Executive … there was absolutely was the feeling, 'Well somebody else had better sort this out'".*[135]

5.229 It was a result of recommendations in the second, more comprehensive, Bull Report that, as Phil Dennett sets out in his first statement, separation was made between services for children – Children's Services on the one hand (field social work services) and, on the other hand, a Children's Executive responsible for residential, secure, the YAT and co-ordination with other agencies. Originally the post of Director of Service was created but, following a failed recruitment drive for candidates in the UK, Phil Dennett was appointed as "Service co-ordinator for the Children's Executive".

Williamson Report (2008) and Williamson Report: Implementation Plan (2009)

5.230 Andrew Williamson, formerly Director of Social Services for Devon County Council, was appointed by the Chief Minister and the Council of Ministers of the States of Jersey in 2007 to review the appropriateness of policies and procedures produced by the JCPC, to assess the extent that these were followed and to review the standard, experience and qualifications of staff working in social services. He made unannounced visits to Greenfields, La Preference, Heathfield and BYD and carried out 65 interviews with complainants as well as meeting with staff. He was helped by Peter Smallridge, a former Director of Kent Social Services. Among other

[135] Day 90/85

recommendations, the Report recommended the creation of the post of Minister for Children, the appointment of an external independent reviewing officer and an external inspection to review Children's Services annually.

5.231 Tony Le Sueur was allocated to work alongside Andrew Williamson. In preparation for Andrew Williamson's visit, and in his role as Children's Service Manager, he produced a paper for the Children's Executive: "*The Future of Children's Residential Care*".[136] As he told the Inquiry, what was set out in the paper was "*deliverable*", "*If there had been the resourcing and political commitment to make it work we certainly could have delivered*".[137]

5.232 Tony Le Sueur told the Inquiry that the Williamson Report was, in his view, *"very short on detail"*. The Report was subsequently reviewed by Professor Ian Sinclair as part of the Breckon Scrutiny Report (see below).

5.233 Following the 2008 Report, in 2009, Richard Jouault was responsible for co-ordinating the Health and Social Services' Department's response to the 2008 Report. This was set out in the 84-page Williamson Implementation Report, which, in essence, was a costed feasibility study looking at the Williamson recommendations. One of the issues identified in the Implementation Report was that social workers in Jersey were having to manage excessive caseloads. Notwithstanding his role, Richard Jouault[138] told the Inquiry that he was unaware, until 2009, that social work caseload in Jersey had become a significant risk factor for social workers in carrying out their work effectively.[139] Only at that point was he aware, as he described it, of the "*specific detail*". He remembered that "*there was a great deal of energy and desire from the Council of Ministers to invest in the priorities of the Williamson Plan*".[140] When asked whether at any point he concluded that Social Services were not fit for

[136] WD006042
[137] Day 90/92
[138] Managing Director, Child and Social Services, 2012–2014
[139] Day 93/100
[140] Day 93/102

purpose Richard Jouault replied: "*I think my view was that increased investment would assist them deliver their job.*"[141]

Health, Social Security and Housing Scrutiny Panel: Co-ordination of Services for Vulnerable Children Sub-Panel Review: the "Breckon Report" (2009)[142]

5.234 The Scrutiny Panel, chaired by Senator Alan Breckon, highlighted in its report low morale in Social Services, poor standards of service and resources misdirected to management rather than to frontline staff.[143] In his foreword, Senator Alan Breckon declared that there was a need to "do more than Williamson". The Report made what is described as 32 "*key findings*", identifying the need for "*a clear line of accountability*" and a robust "*whistleblowing*" and advocacy procedure. The management structure of Children's Services and the Children's Executive "*must be reviewed as a matter of urgency*" to ensure "*clear accountability, responsibility and management structures to deliver effective services*". The Report stated that CAMHS was "*critically understaffed*" and unable to treat adequately *"large numbers of children and young people in need of help".*

5.235 The Report was critical of how Children's Services was managed: *"It seems that there is a tendency within Children's Services to allocate resources to the management structure when they could far more usefully be diverted to the operational frontline workforce. This trend will need to be reversed if we are to curb what appears to be an inexorable decline in both staff morale and the standard of staff delivery.*" When asked whether he thought that the decline had been reversed, Richard Jouault thought that an improvement had subsequently been identified in the Scottish Care Inspectorate report three years later.[144] In responding to the Scrutiny Panel's view that flexible care packages should be tailored depending on the child's needs, Richard Jouault agreed, and believed that, as a small island, Jersey was ideally place to

[141] Day 93/168–169
[142] WD006407
[143] Day 93/117
[144] Day 93/120

provide a bespoke service. It was, he added "*Important to place children at the centre of care*".

5.236 When asked to comment on specific aspects of the Report, Marnie Baudains agreed that it was "*very difficult*" to recruit staff: "*Jersey has its limitations upon what it can offer really able and ambitious social workers.*" She agreed that there was confusion about strategic decision making within Children's Services and the Children's Executive: "*the actual structure was not functional*". She was clear that Children's Services had been under-resourced.[145]

5.237 When she left Children's Services in 2011, the problem of recruitment was still a pressing issue.

5.238 Allegations of serious unprofessional behaviour among senior management existed, according to Marnie Baudains. The recommendation in the Breckon Report that such allegations be investigated by an outside body was never implemented. There was, said Marnie Baudains, no attempt to investigate these allegations and *"the same people were left running the services*".

States of Jersey: Inspection of services for looked after children: A report for the Children's Policy Group: Scottish Care Inspectorate (2012)[146] and Follow-up Inspection (2013)[147]

5.239 The Scottish Care Inspectorate (the successor to the Social Work Inspection Agency) was commissioned by Jersey's Children's Policy Group to carry out an independent inspection of its services for looked after children. This was in line with one of the recommendations of the Williamson Report for there to be annual independent external inspections. The Inspectorate found that: "*The perception of a range of partners, providers, foster carers and staff was of a political body largely unsympathetic to the needs of looked after children,*

[145] Day 91/130–133
[146] WD007039
[147] WD007087

within which there were clear notions of those who were 'deserving' and 'undeserving'." They found a lack of strategic planning in Children's Services.

5.240 The Inspectorate concluded that the views of young people in residential care were ignored. Rules were emphasised rather than positive aspects of care. This is an echo of the 1980 Pilling Report, which described HDLG as a facility managed on a system of rules rather than on a system of care.

5.241 The Inspectorate concluded that there was a need for greater political support for social services in Jersey. When asked to comment, Marnie Baudains told the Inquiry that the lack of political will was partly due to Children's Services being within the HSSD and health being the priority for many. Tony Le Sueur agreed that there was a need for greater political support for social services.

5.242 Its recommendations included the following:

- The views of looked after young people should be collated: *"processes should be put in place to develop ways of allowing them more say regarding their care"*.
- All looked after children and young people *"must be provided with information about how to make a formal complaint"*. The Inspectorate had found that children and young people had *"little say or control over the way things were run within homes and complaints about their care were taken seriously"*; there was little opportunity for them to seek external support.
- Children's Services should develop *"a systematic and comprehensive approach to service planning".*
- Training for residential care staff in therapeutic crisis intervention (TCI) and child protection should be reviewed "urgently".
- Children's Services should set up a performance management system.

5.243 The Scottish Care Inspectorate carried out a follow-up inspection in 2013. Some positive steps were being taken, and "*Overall services for looked after children and young people in Jersey are improving*", but the Inspectorate

concluded that there was "*an absence of a vision for residential child care in Jersey*".[148]

5.244 Richard Jouault was asked whether he was surprised at the criticisms set out in the Scottish Care Inspectorate Report in 2012. He was also asked to address the view of young people in residential care who considered that their views were ignored and their complaints not taken seriously, and that rules were emphasised rather than positive aspects of care – an echo of what had been reported many years before.[149] He sought to address both aspects. He told the inquiry that "*There needs to be many opportunities for young people to express their concerns*".[150]

Recent working perceptions of Children's Services: Glenys Johnston and Jo Olsson

5.245 **Glenys Johnston**[151] was appointed in 2013 as Independent Chair of the Safeguarding Children and Adults Partnership Boards. At the time of giving evidence to the Inquiry she was an associate government inspector of Children's Services and also interim Chair of the Safeguarding Board for Northern Ireland.

5.246 Glenys Johnston made the following points in evidence:

- Jersey does not have any equivalent to Ofsted, to exercise oversight of the Safeguarding Boards.
- The lack of financial resource for multi-agency training and supervision has an impact on the effectiveness of staff. Glenys Johnston was not confident that existing staff were familiar with the threshold guidance criteria.
- The Safeguarding Board has no statutory power and therefore issued a memorandum of understanding which all agencies have signed. This

[148] WD007087/13
[149] Day 93/143–146
[150] Day 93/144
[151] Day 134; WS000710

recognises that all are required to co-operate with the Safeguarding Board.

- Glenys Johnston was confident that children in care in Jersey knew to whom to make a complaint of abuse: *"Whether they would do so is different. Most children don't."*

- Systems were not yet in place in Jersey to support and encourage children to come forward with such complaints. There were no children's rights officers. There were no comprehensive advocacy services. Glenys Johnston had been raising this for "*some time*" with the States of Jersey, to no avail.

- Unannounced visits were now being made to foster parents and children were seen on their own.

- In 2015, Mary Varley (a recently retired Ofsted inspector) carried out a full audit of Jersey social work and child care practice. Glenys Johnston described the Varley audit as *"damning"*.

- The Varley audit had found that:[152]

> *"The quality of assessments was poor; children in care were not visited on a regular basis; clear, up-to-date multiagency guidance on the purpose and conduct of the care planning meeting was very limited some agencies do not understand their role in child protection conferences; and there was a reported failure to take action without delay*."[153]

5.247 Glenys Johnston told the Inquiry that the number of children in care in Jersey was rising. This she attributed to more appropriate intervention, although there was still insufficient management information available to make a proper assessment. This affected the Safeguarding Board's ability to challenge critically.

[152] WS000710/28
[153] WS000710/28

5.248 She had constantly pressed Children's Services for useful management information but it was difficult to hold Children's Services to account. She told the Inquiry that it had been known for *"some time*" that a performance management system was needed but that "*we still don't have one*"*.*

5.249 She considered the Safeguarding Board to be one of the best she had worked with in terms of commitment; when asked if the Board in practice struggled to push forward change, she replied: "*I think that we have made improvements, we have done some things that needed to be done. I think that children are safer but we have a very long way to go.*"[154]

5.250 Glenys Johnston said that Jersey's Children's Services' practice was some 15 years behind that of the UK. *"There are so many aspects of the work that is poor."* Child care legislation needed to be prioritised. SCRs had identified "*very, very poor practice".* Practice had been allowed to be "*inadequate for too long".* Glenys Johnston said that there were very recent SCRs showing poor practice, and not simply in the past.

5.251 Some lessons had been learned from SCRs, but improvements had not been made. Glenys Johnston agreed that six years was sufficient time for improvements to have been made since a seminal SCR had been carried out in 2010.

5.252 If Children's Services had been inspected 18 months prior to her giving evidence, it would have been rated "*inadequate*", in her view.

5.253 Glenys Johnston could not be sure whether a child would be safe in care in Jersey, because "*I don't have enough information*".

5.254 At the date of giving evidence, **Jo Olsson**[155] was an interim Senior Manager working with UK local authorities to improve existing social service provision. In 2014, she had taken up the post of Interim Director of Children's Services in Jersey. She found the professional culture "*hierarchical, paternalistic and*

[154] Day 134/218
[155] Day 138; WS000714

patriarchal". Social work practices were "*underdeveloped*". She found that managers did not know what they were supposed to be doing: "*leaders were struggling to lead due to their lack of understanding of complex issues of child protection".* There was not what she described as *"enough fresh air in the system … too many internal promotions over too long a period*".

5.255 Jo Olsson told the Inquiry that she met this problem by bringing in "*the outside world*"*.* The senior management team had to come from outside Jersey.

5.256 In her view, two leaders of the service did not have the professional experience to lead the service. Under Joe Kennedy, the model at Greenfields "*was one of containment and behaviour management*". She would have expected a qualified social worker to have been appointed in Joe Kennedy's role. She had appointed James Clarke to work with Children's Services. He had introduced safer recruitment practices and had provided a "*more holistic approach to try to create therapeutic environments and relationships that enable children to recover from the adverse experiences that they have had*".

5.257 Jo Olsson told the Inquiry that, until she arrived, Children and Adolescent Mental Health Services (CAMHS) did not prioritise children who needed access to the service. She introduced a rapid improvement plan for CAMHS.

5.258 Jo Olsson acknowledged that there was a difficulty making decisions about senior staff not from Jersey: "*In Jersey, if you lose your job, then you may lose your right to work and your home. There are limited options for alternative employment and you may be left with little option but to leave … The result of this in the work environment is that it affects the willingness of managers to use formal systems to challenge poor practice."*[156] She thought that it was a very difficult problem in Jersey to challenge one's peers.

5.259 Decisions were not child-centred decisions and practice was not child centred. Jo Olsson said that she found a *"quality and standard of practice in Jersey that left children very, very vulnerable"*.

[156] WS000714/11

5.260 She felt that senior management "*were not prepared to engage in a thoughtfully considered explanation of what the risks and issues for the child might be"*.

5.261 Deficiencies in the *2002 Children (Jersey) Law* left Children's Services at risk of being *"overwhelmed*". There was no co-ordinated infrastructure below statutory intervention.

5.262 Jo Olsson had commissioned four reports from Mary Varley,[157] previously referred to above. These had been undertaken in May and June 2015: "*Mary Varley's audit confirmed that social work practice in Jersey was very poor. The practice in relation to looked after children mostly met minimum standards but across all other aspects fell below minimum standards. Poor practice was prevalent and management were not doing enough to drive up standards."*[158]

5.263 Jo Olsson's assessment was that leaders were out of their depth and consequently failed to deal properly with cases brought to their attention:[159] *"I did not see any evidence that indicated any organisational complicity in the sexual or other abuse of children, but instead the patriarchal and chauvinistic culture of the Department had failed to protect children appropriately."* She had found that notwithstanding this, there was commitment in Jersey at every level to improvements that were being proposed.

The X children: expert reports

5.264 Expert reports were prepared in the context of a claim in negligence against the Department for Health and Social Services, alleging that the Department failed to remove children from an abusive setting in a timely fashion. The children were thereby exposed to harm that they would otherwise have avoided had they been taken into care sooner.

[157] Retired OFSTED inspector
[158] WS000714/18
[159] WS000714/14

5.265 In making good their case, the X children had had to rely upon expert social work opinion to review the approach taken at the time by individual CCOs and Children's Services generally. Maria Ruegger was instructed on behalf of the X children. Stephen Pizzey[160] was instructed on behalf of the HSSD. The period covered by their reports was from 1991 to 2000. As a starting point, the experts considered what would have been acceptable social work practice over the period. They then set that standard against the social work practice that had in fact been followed. Although the reports were prepared with a specific purpose in mind, they provided an insight into the standard of generic social work practice in Jersey at this time.

5.266 Maria Ruegger identified in her reports[161] general and specific comparisons and failings. The following are of note:

> "*Jersey child protection procedures published in 1991 were based on practice principles identical with practice in the UK, for example the paramountcy of the child's welfare and supporting children in their families where possible. There were some minor differences in content, for example Jersey procedures are applicable to children under 17 whilst the UK procedures do not mention age. However the practice in this respect was similar in both jurisdictions …* "[162]
>
> "*The Jersey Child Protection Guidelines – Working Together – Interagency Procedures for the Protection of Children in Jersey, issued in 1991, run to 21 pages. The UK procedures upon which they were based run to 126 pages. It is not clear why senior management in Jersey took the view that Jersey practitioners engaged in child protection work did not require a similar level of guidance to their UK counterparts. After the 1991 procedures were published there is nothing disclosed to support further updating or monitoring of their effectiveness until late 1996, when the Jersey Child Protection Committee was formed to address the deficiency. It was then another two years before revised policies were issued. In the intervening period, that is between 1991 and 1998, Child Care Officers and other professionals engaged in child protection work in Jersey had only sparse guidelines within which to practice. The result can only have been to create an environment in which poor social work practice could flourish; while UK guidance remained relevant and applicable, it was not necessarily consistently applied or understood by all Child Care*

[160] Head of the Social Work Department, Great Ormond St Hospital
[161] WD008973/4 to WD008982
[162] WD008973/2

> *Officers. This in my view amounts to systemic failure at senior management level".*[163]
>
> *"Whereas in England and Wales interagency arrangements have been in place in all local authority areas since the 1960s, such arrangements do not appear to have been put in place in Jersey until 1996. Interagency guidance in England and Wales was in place in all local authority areas since the 1960s whereas in Jersey the first such guidance appears to have been issued in 1991."*[164]
>
> "*My view is that the service children and families received (in Jersey) were directly dependent on the interest and skills of the social worker which is indicative of a lack of management responsibility for quality assurance*."[165]
>
> *"Following a five-year period in which there was no body responsible for developing and leading Children's Services and inter agency child protection practice, the JCPC was formed. Policies and procedures were developed over the period 1997 to 2000. It is not clear why, given that so much reliance was placed on the inter agency child protection guidance developed in the UK and on other literature that supported UK practice, that Children's Services senior management considered that Jersey practitioners needed so much less guidance and structure than their UK counterparts doing the same job."*

5.267 In the period 2004 to March 2014, a number of SCRs were considered by the JCPC (now Jersey Safeguarding Partnership Board). The time span of the cases considered ranges from 1990 to 2014 and thus provides some insight into child protection practice over several decades. The SCRs include the accidental death of a child whose family had many years of contact with Children's Services; the sexual abuse of a boy in a youth organisation; the neglect and abuse of children in one family over a 13-year period; teenage suicides and child murders. The findings of the SCRs were unhappily consistent and included:

- poor assessment practice;
- a failure, in several instances, to follow child protection procedures;

[163] WD008973/4
[164] WD008977
[165] WD008982

- inadequate responses to signs of child distress or signs of neglect; and abuse
- poor social work practice; and
- inadequate paediatric assessment.

5.268 SCRs in 2010 and 2014 made reference to lessons not having been learned from previous SCRs. Consequently, children were exposed to the continuing risk of harm as a result of a failure to address recommendations made in the SCRs.

Findings: The political and other oversight of children's homes and fostering services

5.269 The evidence of John Rodhouse, Marnie Baudains, Phil Dennett, Tony Le Sueur and Glenys Johnston, taken as a whole, suggests that there has been, over a long period of time, no political appetite for addressing social issues concerning the welfare of children.

5.270 There was no structure in Children's Services until Patricia Thornton's appointment in 1959 as CO. Patricia Thornton set up the Children's Department and had a "*sound professional eye on things*". She was a committed and dedicated CO. Patricia Thornton maintained oversight of HDLG from 1959 to 1968, although there was no line management between the Superintendent and her.

5.271 The focus for Children's Services has been on structure and process, not on the quality of the leadership, performance of staff or the experience of the children within the system. Leadership has been lacking; the primary focus has been on administration and hierarchy.

5.272 Many detailed reports have been produced over the years, and a large number of recommendations have been made. As noted in this Report, some recommendations have been implemented; many have not, including some of significance.

5.273 Cost and prioritisation have been constant issues holding back progress and development in Children's Services over a long period.

5.274 Notwithstanding the restructuring and reorganisation of Children's Services during this time, there has been a failure to adopt a strategic approach and to develop policies to meet the needs of children and young people in Jersey. Such strategic reviews as there have been in the more recent past have not been adequate.

5.275 Jersey has failed to recruit and retain senior social work staff in management positions in Children's Services. Consequently, it has promoted from within social work staff who have lacked the necessary leadership qualities and senior management skills and then failed to provide them with the necessary support. This is not to doubt the obvious commitment and dedication of those individuals in their roles as CCOs.

5.276 Over the past 30 years, Jersey became disconnected from mainstream social care developments and practice. There was no real investment in developing skills to work at strategic or case level with looked after children. There was no commitment to carrying out proper and continuing assessments of children once in care or to proper and considered planning while children remained in care. As a number of witnesses told the Inquiry, Jersey did not know "what good looks like". For instance, we note that it was only in February 2011 that island-wide multi-agency policies and procedures were implemented. Jersey produced limited guidance in the wake of the UK *Children Act 1989* and no guidance and limited training to accompany the *Children (Jersey) Law 2002*.

5.277 The States of Jersey failed, and has continued to fail in the light of recent reviews by Glenys Johnston and Jo Olsson, to pay sufficient attention to effective and appropriate governance. The role of a statutory body is not simply to ensure that operationally individual cases are being dealt with adequately, but also to provide the necessary strategic oversight to ensure that there are adequate safeguards for the protection of children within the system.

5.278 Jersey has consistently failed to understand the type of service and practice required to meet the needs of vulnerable and abused children. We heard substantial evidence about recent re-organisation, structural changes and proposed implementations, but have been dismayed by the continued systemic shortcomings identified by Glenys Johnston and Jo Olsson. In short, we have seen no evidence that the States of Jersey has, at any time, understood or embraced its role as corporate parent.

5.279 In more recent times, we find that there has been an absence of adequate leadership in Children's Services.

5.280 We do not accept that the scale of the island justified the limited options available to Children's Services once a child was admitted into care, particularly during the existence of HDLG. We think that the limited options demonstrated the absence of any real political vision and informed policy for children in the island over a long period.

5.281 Although we accept that pressure on resources is a feature common to many local authorities in the UK, we find that Jersey has consistently failed, over a long period, to resource adequately and to commit to strategic planning for children in care. We were told repeatedly in evidence, and find, that there has long been a lack of real political will or motivation to ensure that children's services in the island were properly resourced and supported.

5.282 As referred to above, child protection guidelines/procedures were initially published in 1991, and were published in 2000, 2005 and 2011. They appear to us to have had little impact on the quality of social work practice. We come to this conclusion in the light of the evidence that we heard and read from several witnesses, including Daniel Wherry, Pauline Vautier, DI Alison Fossey and Janet Brotherton.

CHAPTER 6

Changes in Child Care Practice and Policy over the Years

6.1 In opening to the Inquiry in July 2014, Counsel to the Inquiry presented a summary of the major legislative changes in Jersey and in the UK alongside developments in policy reflecting changes in society. This was subsequently substantiated by a report commissioned by the Inquiry, "*A review of services for children in care in the UK since 1945 and a comparison with the situation in Jersey*", by Professors Roger Bullock and Roy Parker (the "Bullock Report").[1] The Bullock Report discusses major societal changes and the legislation that followed, comparing England and Wales with Jersey social legislation. The Report is at Appendix 6. It should be read in tandem with the evidence of Richard Whitehead, which complements it. Richard Whitehead conducted a review of child care legislation in Jersey from 1945 (see Appendix 7).[2]

Legislative development

6.2 The consideration of UK legislation serves several ends. First, it may be taken as a reflection of child social policy in the UK at the time. Secondly, it may be viewed in comparison with Jersey legislation in force at the time. Thirdly, the relative frequency of legislative change in England and Wales may be seen as a reflection of changing societal norms influencing policy, which in turn initiates legislative change.

6.3 Richard Whitehead[3] provided a statement to the Inquiry on the history and development of Jersey child care legislation from 1945.[4] His statement and a chronology of Jersey child care legislation since 1945 are provided at Appendix 7. The following points emerge from his evidence to the Inquiry.

[1] EE000136
[2] EE000261 and EE000262
[3] Principal Legal Adviser, Director of the Civil Division of the Law Officers' Department
[4] EE000261

The development of child care legislation in Jersey, although independent of the UK, has been influenced by and is modelled on UK legislation. As Richard Whitehead noted: "*There are many examples showing that Jersey closely follows UK legislation where appropriate … in some cases changes to UK legislation provide a specific trigger for changes in Jersey legislation, in other cases there has been a general recognition that Jersey legislation requires updating.*" He told the Inquiry that, as a matter of "good practice", Jersey departments keep under review prospective changes in the UK, saying: "*almost all child care legislation in Jersey mirrors UK child care legislation to some extent*".

6.4 The introduction of legislative change in the island has tended to be behind that of the UK; for instance, the *Children (Jersey) Law 1969* mirrored in certain respects the UK's *Children Act 1948*. The need for all-encompassing children's legislation was first raised in 1960 by Patricia Thornton. It was recognised that the island's child care legislation was "*so inadequate for modern needs*" and that the proposed law was "*based on United Kingdom legislat*ion". At the time, the Attorney General (AG) was concerned that "*our existing laws on children are extremely inadequate and we find that we are continually having to try to improvise in order to keep in step with modern ideas on child care and treatment*".[5] The delay was due in part to the UK Home Office giving advice to Jersey on the effects of the abolition of approved schools in the UK, with no corresponding provision in Jersey.

6.5 Another example of mirroring legislation was the introduction of the *Children (Jersey) Law 2002*, planning for which began in 1989, in the light of the UK *Children Act 1989*. A review of existing Jersey law was finalised in 1991. The initial approach was to bring in piecemeal amendments to the *1969 Law*. This was seen as "*risky*" by the Law Draftsman. When the draft *Children (Jersey) Law* was presented to the States in 1991, it was described as being "*a comprehensive new Law, based on the United Kingdom Children Act 1989 … [creating] a framework capable of responding to the wide variety of child care arrangements that exist today*". One of the debates in Jersey over the draft

[5] EE000184

Bill was the extent to which the Jersey law would mirror the shift away from parental rights over children to parental responsibility for children.[6] It did, in fact, do so.

6.6 The *2002 Law* did not come into force until 2005: Richard Whitehead told the Inquiry that "*considerable subordinate legislation*" was needed and the Law Officers' Department was stretched. He said that, as a very small jurisdiction, "*some major changes just take a long time because there are not very many people working on them … in Jersey it is a small administration dealing with almost the same amount of issues, it is purely and simply a lack of resources*".[7] Part of that subordinate legislation included the prohibition of corporal punishment in voluntary homes.[8]

6.7 In explaining the time lag between UK and Jersey legislation, Richard Whitehead suggested that "*for various reasons some of the complexities found in the UK model will be unnecessary in a smaller jurisdiction such as Jersey*". He reflected: "*It takes quite a long time to get to the position where the legislation is ready to be introduced in Jersey, only for the Jersey authorities to learn that there is change about to take place in the UK*" and then deciding whether to go ahead or wait.[9]

6.8 Until the mid-1970s, policy and legislation were promoted by the Committees; in the mid-1970s, a Policy Advisory Committee was appointed, becoming the Policy and Resources Committee in 1989 (now the Legislation Advisory Panel). In the early 1990s, Jersey drew up its first legislative programme. As set out by William Bailhache,[10] the Law Draftsman is not accountable to the AG but has a close relationship with the Law Officers' Department. Drafting instructions would be provided by the relevant department to the Draftsman.

[6] Day 15/132
[7] Day 15/99
[8] Day 15/174; Children (Voluntary Homes) (Jersey) Order 2005
[9] Day 15/76
[10] WD009017/7

6.9 Richard Whitehead's personal impression was that the change to ministerial government brought about a more personal engagement by politicians with particular areas of responsibility and greater political impetus.[11]

6.10 Wendy Kinnard, former Home Affairs Minister, said that legislation relating to the financial industry would "*definitely"* take priority due to the influence of outside agencies (such as the IMF).[12] William Bailhache QC thought that financial legislation was a priority, but doubted that it took priority over other pieces of legislation.[13] John Edmonds said that criminal law and procedure did not receive sufficient drafting time compared with, for example, financial services legislation, and that Jersey continued to play "catch-up" with the position in England and Wales, often lagging 20 years behind. However, he went on to say that this had been addressed, to an extent, as a result of a better structure for criminal justice policy introduced in 2013.[14] Deputy Mike Higgins thought that legislation relating to financial regulation was certainly *"top of the pile".*[15] Frank Walker, former Chief Minister, explained that they were able to get financial legislation through the States *"relatively quickly"* and with "*virtually no opposition".*[16]

6.11 Despite the above, Ian Gorst (Chief Minister) told us[17] that it was not fair to suggest that financial legislation received greater priority than child care legislation. He said that they had put extra resource into law drafting departments, and created a social policy unit in the Chief Minister's Department.

[11] Day 15/182
[12] Day 135/16
[13] Day 127/8
[14] Day 126/134
[15] Day 130/78
[16] Day 123/6
[17] Day 144/175–177

Child care practice and policy

6.12 Professor Bullock gave evidence to the Inquiry over two days. A large number of reports and papers were supplied to the Inquiry, providing necessary reference points for an understanding of the social and professional norms.

6.13 The Bullock Report (Appendix 6) and its accompanying documents, which we accept, meet, in large part, the requirements of Term of Reference 5. They set out, as we also find, a chronology of significant changes in child care practice and policy over the relevant period in Jersey and in the UK as well as the "social and professional norms which services operated" in Jersey.

6.14 The *Children and Young Persons Act 1933*, in England, from which the *1935 Jersey Law* was derived,[18] introduced, for the first time, a form of child care proceedings. It also rendered into statutory form an offence of cruelty to children. In creating the concept of a "*fit person*" to whom a child "*in need of care or protection*" could be committed by order of the court, the role of the State in the care of a neglected child was further crystallised, moving away from the criminalisation of those children on society's margins. It meant that an individual, local authority or voluntary organisation could be appointed a "*fit person*" to take care of a child, as an alternative to the child being placed in a custodial institution. This is what came to be known by the shorthand of a "*fit person*" order. The *1933 Act* also provided for supervision orders, placing a child under the supervision of a probation officer. The Act brought together the criminal law and the law relating to child protection. A "*fit person*" order was seen as a direct alternative to an Approved School order, which in turn was seen as a substitute for a remand home.

6.15 When, in 2007, the Scottish Government published "*Historical Abuse Systemic Review – Residential Schools and Children's Homes in Scotland 1950 to 1995"*, the report reflected on the *Children and Young Persons*

[18] LG000001

(Scotland) Act 1937,[19] which followed, in similar terms, *section 1 of the 1933 Act* (cruelty to children):

> "*To suggest that what society accepted as normal should determine practices that we consider abusive today, is to overlook that children in state care were entitled to protection by law. The Children and Young Persons (Scotland) Act 1937, for example, provided most of the fundamental regulation for the welfare and protection of children and young people during the 1950s and 1960s, making it an offence to harm children. Importantly, this Act shows what was known to be harmful to children in 1937*."[20]

6.16 Across the Channel, at the end of the War, child care figures in England and Wales revealed that 4,000 war orphans were being supervised in the community, of which 411 were in care. Out of the 500 hostels set up during the War for evacuated children, 114 remained, accommodating 1,000 evacuees and 500 others under various legal frameworks. Further, 33,000 children were in local authority Poor Law care, spread across a wide variety of accommodation: nurseries, large homes, cottage homes, Family Group Homes, barracks and receiving homes. There were 141 approved schools, housing over 12,000 children. Also, 33,500 were in voluntary homes; 1,500 were in remand homes; around 10,000 were on "fit person" orders; and 14,000 children were in private fostering. In all, just under 125,000 children were in some form of care. Of course, the scale and complexity of the issues inherent in these statistics were entirely different from those faced by Jersey's far smaller community.

6.17 In England, the Government commissioned the Care of Children Committee, chaired by Dame Myra Curtis, to report on the future of services for children in care. At the time, the system was complex, with little or no uniformity of approach. The Committee reported in 1946. It was the first Inquiry of its kind into children in care.

[19] See section 12

[20] GD000207/29

6.18 The Committee visited 451 institutions, as well as foster homes. A passage from the report resonates, in the light of the evidence we have heard in this Inquiry:

> "*We found in many places where the standard of childcare was no better, except in respect of disciplinary methods, than that of say thirty years ago; and we found a widespread and deplorable shortage of the right kind of staff, personally qualified and trained to provide a child with a substitute for a home background. The result in many Homes was a lack of personal interest in and affection for the children which we found shocking. The child in these Homes was not recognised as an individual with his own rights and possessions, his own life to live and his own contribution to offer. He was merely one of a large crowd, eating, playing and sleeping with the rest, without any place or possession of his own or any quiet room to which he could retreat. Still more important, he was without the feeling that there was anyone to whom he could turn who was vitally interested in his welfare or who cared for him as a person."*[21]

6.19 The 1946 Curtis Report made 62 recommendations. The Report emphasised that staff training was highly important in improving the quality of residential care. It attached *"great importance to establishing and maintaining a continuing and personal relationship between the child deprived of a home and the official of the local authority responsible for looking after him*". In practice, it was intended that the delegated Child Officer (predecessor to the social worker) would "*be the friend of those particular children through their childhood and adolescence*".[22] This issue of contact would be of particular importance to children in residential or foster care.

6.20 The Report identified the risk of harm to children in institutions at the hands of those in charge. Witnesses from whom the Committee heard:

> " … *did bring home to us the danger even in an organisation under an authority with an enlightened policy that individuals in charge of groups of children may develop harsh or repressive tendencies or false ideas of discipline, and that children in their care may suffer without the knowledge of the central authority. A code of rules which sets the proper standard is one necessity but it is plain that no code will suffice without regular inspection and constant watchfulness that the right atmosphere of kindness and sympathy is maintained*".

[21] EE000096/68, paragraph 418

[22] EE000096/74, paragraph 445

6.21 The emphasis in the 1946 Report is on the excessive use of physical force. No mention is made of sexual exploitation of children. At that time, society was not alive to the risk of sexual abuse of children in care. In hindsight, the recommendations made about the importance of personal relationships must carry at least as much, if not more, weight in relation to the possibility of sexual abuse.

6.22 The Committee recommended the abolition of corporal punishment in children's homes:

> "*We think that the time has come when such treatment of boys in these homes should be as unthinkable as the similar treatment of girls already is, and that voluntary homes should adopt the same principle. It is to be remembered that the children with whom we are concerned are already at a disadvantage in society. One of the first essentials is to nourish their self-respect: another is to make them feel that they are regarded with affection by those in charge of them. Whatever is to be said for this form of punishment in the case of boys with a happy home and full confidence in life, it may in our opinion be disastrous for the child with an unhappy background. It is moreover liable to grave abuse. In condemning corporal punishment we do not overlook the fact that there are other means of enforcing control which may have even more harmful effects. We especially deprecate nagging, sneering, taunting, indeed all methods which secure the ascendancy of the person in charge by destroying or lowering the self-esteem of the child."*[23]

6.23 The Report was hopeful that, if its recommendations were adopted, there would be fewer children going to Approved Schools. Means of discipline in Approved Schools continued to include corporal punishment and rooms provided to separate one boy from others; both were subject to statutory regulation.

6.24 The Curtis Report was published in the wake of a Home Office Inquiry in 1945, chaired by Sir Walter Monckton, into the tragic death of 12-year-old Dennis O'Neill in foster care. One of the criticisms in the Monckton Report had been the lack of co-ordination regarding visits to the foster home by those responsible for the boy's placement.[24]

[23] EE000096/84-85, paragraph 493

[24] Home Office: Report into on the circumstances which led to the boarding out of Dennis and Terence O'Neill – Sir Walter Monckton 1945 Cmd 6636

6.25 The consequence of the Monckton and Curtis Reports in England and Wales was the enacting of the *Children Act 1948*,[25] the *Administration of Children's Homes Regulations 1951*[26] and the *Boarding Out Regulations 1955*.[27]

6.26 Up to the late 1960s, in England there had been only been one inquiry into the abuse of children, and that related only to physical abuse. That was the Court Lees Inquiry in 1965 – where boys in an approved school had been subject to excessive corporal punishment. A teacher at the school had contacted a newspaper to voice his concerns. In his Report into Court Lees, Edward Brian Gibbens QC set out his approach to accounts provided by boys:

> "*I was informed that almost every boy at Court Lees School had been sent there by the courts for some offence but it does not follow of course that the boys are necessarily to be expected to give false evidence: indeed I thought most of the boys were trying to be truthful in the witness box. However appearances are deceptive, not least the demeanour of children and I consider that I ought not to accept the evidence of any boy, if contradicted by a member of staff, unless it was particularly convincing or corroborated by other evidence*."[28]

6.27 This may be a reflection of what witnesses to this Inquiry felt at the time of their mistreatment: that they would not be believed because of their standing – children in care in a home.

6.28 In their book "*Public Inquiries into Abuse of Children in Residential Care"* (2001), the authors note that:

> "*Physical abuse and neglect of children in residential care has simply not been a major consideration in history. Excessive cruelty in such institutions has only rarely been subject to external response over many centuries. This is probably because in the past harsh regimes were thought necessary and no more than children deserved. Poor and unstimulating environments were very much in evidence in the findings of the Curtis Committee in 1946. While there were no doubt improvements on the quality of residential care after that it is somewhat surprising that between 1945 and the late 1980s there was only one public inquiry into physical ill-treatment of children in care – at Court Lees in 1965. It is of course possible that little such ill-treatment*

[25] GD000011

[26] GD000007

[27] GD000008

[28] GD000014: Administration of Punishment at Court Lees Approved School, Report of Inquiry by Edward Brian Gibbens QC, Cmnd 3367 HMSO 1967, p.12

> *existed. However it is more likely that there was a fair degree of acceptance of physical means of control of a kind which is now no longer seen to be acceptable in care settings … the relatively late arrival of residential care abuse on to the social policy agenda is probably accounted for by the heavy focus on intrafamilial abuse throughout most of the 1970s and 1980s and the relatively low level of visibility of children in residential care … without the prior focus of intrafamilial abuse there would have been little chance of abuse of children in residential care coming to light at all.*"[29]

6.29 Awareness and understanding of sexual abuse did not emerge until the mid-1980s on the mainland. The report of the Cleveland Inquiry in 1988 emphasised the need to take seriously the child's account and to exercise particular care in the way in which children were interviewed. This, and the Clyde Report into the removal of children from their homes in Orkney following allegations of child abuse, focused on sexual abuse – albeit within the family home.

6.30 Two reports came out, in 1985 and 1986, looking at the sexual abuse of children in residential care. The Leeways Report, commissioned by the London Borough of Lewisham in 1985, followed the conviction of the officer-in-charge of offences involving indecent photography of children in the home. The report concluded that children had not spoken out because they had associated their social worker with those responsible for removing them from their homes and because they feared that they would not be believed.[30] The report found that there had been poor management, poor staff selection procedures and poor training.

6.31 The Kincora Report,[31] published in 1986, looked at sexual abuse in nine children's homes in Northern Ireland between 1960 and 1984. Young male staff in different homes had sexually assaulted boys in the homes over a long period of time. As with Leeways, the Report found that children did not disclose because they felt they would not be believed. There was no complaints procedure. Children were not seen alone by their social workers.

[29] Pp.50–51
[30] EE000113/25–26
[31] EE000127

Such complaints were a constant refrain in inquiries and reports throughout the 1990s.

6.32 In 1989, in England, the *Children Act*[32] completely overhauled child care law. It was accompanied by 10 volumes of official guidance and regulations issued by the Department of Health. These are still updated periodically.

6.33 While Jersey established a Child Protection Team in 1989, it did not introduce legislation equivalent to the *Children Act* until 2002, with the *Children (Jersey) Law 2002*. The law came into force in 2005. Jersey did not adopt guidelines equivalent to those that accompanied the UK Act.

6.34 The *1989 Act* in the UK reflected societal change towards the place of the child. In his introduction to "*The Care of Children: principles and practice*",[33] accompanying the *1989 Act*, Sir William Utting, the Chief Inspector of the Social Work Inspectorate, explained the importance of the Act:

> "*The principle that the welfare of the child comes first is the foundation of the responsibilities of social services authorities towards children … Developing a detailed understanding of a child's needs and best interests enables us to take the action required to meet and fulfil them … [the Act] both reflects and requires major changes in attitudes and practice."*

6.35 Detailed guidance was provided on residential care[34] and on fostering. The residential care guidance contained a section on "*Child Abuse in Children's Homes*", addressing the possibility that "*children in a children's home can be abused by a member of staff*". The "Working Together" Guidelines noted:

> *"It must also be recognised that there may be abuse by staff in a residential setting which pervades the whole staffing fabric with the involvement and collusion of several, possibly senior members of staff."*

6.36 In a subsequent report, "*Children in the Public Care*",[35] Sir William Utting was instructed to carry out a review on the monitoring and control of residential child care. He noted that in a residential children's home:

[32] GD000067
[33] EE000143
[34] EE000146
[35] EE000143

> *" … No child should be allowed to have an exclusive relationship with one member of staff. A climate needs to be created in which the possibility of abuse by staff is realistically acknowledged by children, staff, management and indeed the general public."*

6.37 As part of the societal change in England, the *Children's Homes Regulations 1991* banned corporal punishment in community, registered and voluntary children's homes as well as prohibited the deprivation of food and drink and visits as a means of punishment. A ban was also placed in 1991 on the use of secure accommodation in voluntary and registered children's homes. Some 10 years later, in 2001, the UK passed the *Children's Homes Regulations* to provide for the registration and inspection of homes by the newly formed National Care Standards Commission.

6.38 In Jersey, the same prohibitions (except in relation to the use of secure accommodation) were introduced in voluntary homes 14 years later, under the *Children (Voluntary Homes) (Jersey) Order 2005*.[36]

6.39 The Staffordshire "Pindown Report"[37] and the Leicestershire Beck Inquiry led to the setting up of a Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes. It reported in 1992.[38]

6.40 Inquiries continue to be held throughout the 1990s, culminating in the North Wales Inquiry report "Lost in Care" in 2000. Common themes from Inquiry reports continued to include poor staff training and the difficulty children had in making disclosure. The concluding paragraph of the "Lost in Care" report stated:

> *"The accounts we have given of the residential establishments reveal not only how sexual and physical abuse of children can arise and fester but also the extent to which many of the establishments failed to provide an acceptable minimum standard of care children in dire need of good quality parenting … The Children Act 1989 has provided a springboard for many improvements in children's services but the need*

[36] LG000040

[37] LG000040

[38] EE000147: Choosing with Care

for vigilance and further positive action remains if the ever present risk of abuse is to be minimised."[39]

6.41 The *Children Act 1989* was replicated in Jersey to a significant, but not entire, extent by the *Children (Jersey) Law 2002.* The Jersey Law echoes the paramountcy principle but there is less emphasis on the requirement for a multi-disciplinary approach. Comparisons between the Act and the Law are discussed in the Bullock Report.

6.42 An issue in Jersey is that there is no policy unit to draft child care legislation if it is needed.

Findings: Changes in child care practice and policy over the years

6.43 The physical and sexual abuse of children in care poses significant problems for any society. Problems relating to the recruitment and retention of suitable staff and the provision of appropriate supervision occur again and again. However, the number of times that the problem was addressed in the UK in the period under review, compared with the number of times that it was addressed in Jersey, must, it seems to us, be a matter of concern. The delay in adopting in Jersey what was plainly good practice being adopted elsewhere can be explained only by a lack of political and professional will. It is difficult to escape the conclusion that child care was low on the list of priorities for legislative or administrative change.

6.44 Legislation for children in Jersey almost invariably lags behind positive developments in the UK. There is no separate policy division to deal with this within the Civil Service. The development of new legislation is dependent on operational managers being able to devote time to the task amid their other duties. It should be the responsibility of a dedicated policy unit or legal specialist.

6.45 Priority is given within the States to legislation related to the financial life of the island. One result is that children's legislation can take a considerable

[39] Lost in Care, p.825, paragraph 55.09: http://webarchive.nationalarchives.gov.uk/20130124064403/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134777.pdf

time to be agreed. It is unacceptable that the well-being of vulnerable children and young people is not given sufficient priority. Our view is that the principle of “paramountcy” must lie at the heart of the States’ corporate parenting responsibility.

CHAPTER 7

The Evidence of Abuse

Introduction

7.1 Term of Reference 7 requires us to consider the experience of those witnesses who suffered abuse or believe that they suffered abuse.

7.2 The Inquiry has considered allegations of abuse of children in residential children's homes, Les Chênes, Family Group Homes (FGHs) and foster homes. The evidence falls into the following broad categories:

- abuse alleged to have been perpetrated by members of staff, or by foster parents;
- abuse alleged to have been perpetrated by other residents at the homes;
- abuse alleged to have been perpetrated by others, including visitors to homes.

7.3 While abuse perpetrated by family members is outside the scope of the Inquiry's Terms of Reference, our review of the case histories for many children shows that many children in care had previously suffered abuse within the family prior to their admission into care. For some, the care system did little or nothing to better their lives.

7.4 It is not the function of the Inquiry to make findings of fact about individual allegations of abuse, but rather to consider the settings in which abuse allegedly occurred, and to identify whether there were cultures in which abuse was permitted to flourish, and whether appropriate steps were taken to deal with abuse when it occurred. Findings on these issues are made in other chapters of this Report.

7.5 The States of Jersey did not provide in the Terms of Reference any definition of the word "abuse". We have applied an objective test, measured by society's standards at the time of the alleged abuse. We have based our definition on

that adopted by the Historical Institutional Abuse Inquiry in Northern Ireland and by the World Health Organization. "Abuse" was behaviour that either:

- involved improper sexual or physical behaviour by an adult or another child towards a child; or
- in the case of emotional abuse, was improper behaviour by an adult or another child that undermined a child's self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or
- amounted, through acts or omissions, to neglect of the child; or
- took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships, which ignored the interests of the children or failed to put a stop to such policies and practices.

7.6 Any definition of abuse must be considered with reference to the acceptable standards of the time. This is of particular relevance to allegations of physical abuse. Some witnesses maintained that physical abuse complained of constituted reasonable chastisement in accordance with standards accepted at the time. No question of differing social standards applies in the case of allegations of sexual abuse. No sexual contact of any sort with a child has been acceptable during the period under review.

7.7 In deciding whether there was "systemic failing" in relation to any institution we have adopted the definition submitted by Counsel to the Inquiry in opening:

> *"A 'systemic failing' by an institution consists of either:*
>
> *(a) a failure to ensure that the institution provided proper care, or*
>
> *(b) a failure to ensure that the children will be free from abuse so far as is reasonably possible, or*
>
> *(c) a failure to take all proper steps to prevent, detect and disclose abuse, or*

(d) a failure to take appropriate steps to ensure the investigation and prosecution of criminal offences involving abuse."

Witness recollection

7.8 The evidence of many residents was that they had a happy childhood in residential or foster care and did not themselves experience or witness any abuse. Others tell a very different story, alleging regimes of brutality and incidences of physical and sexual abuse. The fact that accounts may be inconsistent, one with another, does not necessarily mean that one or the other is not telling the truth. The differences in the accounts given may have a number of explanations. Each child had a different experience and may not have seen or experienced things that others did. Recollections may fade or alter with the passage of time.

Approach to the evidence

7.9 Some evidence was given to the Inquiry in the form of oral testimony, where the account given by the witness could be tested by reference to documentary evidence, and his or her credibility assessed. A significant amount of the evidence of abuse considered by the Inquiry arose from witness statements given to the SOJP, or to the Historic Redress Scheme. These accounts were read into the record by Counsel to the Inquiry in order to fulfil our function of making this evidence public. It is noteworthy that, in many cases where evidence was read into the record during Phase 1a, there were available contemporaneous documents from the same witness, whether from Children's Services records, Police records, Redress Scheme applications or Committee minutes etc. These documents were valuable in demonstrating consistencies or inconsistencies in the accounts. All material presented in oral evidence or read into the record, redacted where necessary, has been uploaded to the Inquiry's database.

7.10 Nonetheless, the Panel has given careful consideration to the weight to be attached to evidence that was not tested or explored in oral testimony.

7.11 The sheer number of potential witnesses and the 70-year time span of the period under review meant that it was not practicable to call oral testimony from every single witness with something relevant to contribute. However, the Inquiry has considered all relevant evidence, irrespective of its form or its source, in order to do justice to the extensive Terms of Reference.

7.12 The table at Appendix 2, entitled “Histories of People who Experienced Care in Jersey”, summarises the experiences of all former residents whose evidence we have considered in the course of the Inquiry. We found an overall consistency in the accounts that we heard. We pay tribute to the courage of all those who shared their childhood experiences with us.

Findings: The evidence of abuse

7.13 We are quite satisfied, on the evidence before us, that many instances of physical and sexual abuse, and emotional neglect, were suffered by children in the care of the States of Jersey throughout the period under review.

7.14 The nature and extent of the abuse and neglect have had far-reaching consequences for many of them throughout their adult lives.

CHAPTER 8

Reporting of Abuse

8.1 The first issue to consider under Term of Reference 8 is how and by what means concerns about abuse were raised and how, and to whom, they were reported. We then have to establish whether there were systems in place for raising concerns. Finally, we have to consider whether any systems that were in place were adequate, and establish any failings they had. Term of Reference 4 is also relevant in this context, as the Inquiry is required to consider the effect of the societal and political environment on the reporting or non-reporting of abuse.

8.2 The position of the States of Jersey as advanced to this Inquiry is that:

> *"Practices have changed drastically over time, with increased State involvement, the introduction and prominence of a governance culture and a changing and more modern society".*

8.3 Without doubt, that is what one would have expected. Society has changed considerably over the decades, whether one looks at Jersey or at the UK. We have heard evidence of the changes that have occurred in Jersey, as discussed particularly in Chapter 2.

8.4 In its final submissions, the States of Jersey dealt in generalities but did not address the question posed in Term of Reference 8: **whether systems existed to allow children and others to raise concerns** etc. The Panel therefore sought its assistance by way of supplementary submissions addressed to the question.

8.5 In its oral submissions[1] the States of Jersey said this:

> *"Data is limited in terms of reporting systems that operated historically. Certain cases appear to have been dealt with appropriately at the time and illustrate that there were systems in place that worked at times".*

8.6 It goes on to cite a 1961 instance. On 18 January 1961, the Children's Sub-Committee (CS-C) held a meeting to consider allegations made the previous

[1] Day 145/40

day regarding the conduct of Peter Brooks, a Housefather at Haut de la Garenne (HDLG).[2] Peter Brooks admitted having a relationship and having been in the same bed as a 14-year-old resident boy. Following that meeting, Peter Brooks was arrested by the States of Jersey Police (SOJP).

8.7 The case of Peter Brooks is one of a small number of cases brought to our attention in which there was disclosure to staff by a child and action taken and is one of very few before the late 1980s. The CS-C meeting was attended by three co-opted members from the Executive Committee, by Patricia Thornton and by the Deputy Superintendent. There is no record available to the Inquiry as to whether steps were taken to review procedures in the Home, although we note that the Education Committee was informed and that the matter was referred to the Attorney General (AG).[3]

8.8 The available evidence regarding this incident is that the 14-year-old boy felt able to disclose the abuse, that his account was taken seriously and that the incident was reported within a short time to the Sub-Committee and to the Police.

8.9 There is no evidence that there was a system in the Home at that time to facilitate the reporting of abuse to staff. This incident was treated as self-contained, which was common practice during this era.

8.10 A decade later, there was a memorandum[4] dated October 1969 from Colin Tilbrook to all staff at HDLG. Colin Tilbrook wrote:

> *"I would also seek to remind everybody that discussion with outside bodies on individual children from the general organisation at Haut de la Garenne should be left to the Superintendent. The nature of our work here must be treated at all times with absolute discretion and confidence must at all times be kept. We deal with very personal … problems and the less talk there is about them the better for all concerned and this must apply with equal force as far as any individual member of staff is concerned."*

8.11 The Inquiry has heard allegations against Colin Tilbrook of serious abuse, as set out in Chapter 9 (9.39). He resigned as Superintendent in 1973.

[2] WD001167/3 and WD009445
[3] WD001167/3 and WD009445
[4] WD002600/6

8.12 The States of Jersey submitted, on the one hand, that *"the memorandum might tend to indicate the lack of a culture of openness and transparency, where staff could and should raise concerns directly with, say, the Children's Officer or the State of Jersey Police"*. It goes on to observe, quite rightly, that *"caution needs to be taken when considering such memoranda, particularly as being representative of a general approach across the homes and agencies"*.

8.13 Without making any findings on this specific point, one possibility must be that Colin Tilbrook wrote that memorandum to serve his own interests and to stifle discussion about improper behaviour within the Home.

8.14 On 29 November 1973, the Education Committee minuted[5] an allegation that Gordon Wateridge, a Housefather, had assaulted a boy at HDLG. The Committee resolved that, in the event of the allegation being proved, Gordon Wateridge should be dismissed forthwith. There is no documentation available as to whether the assault was reported to the SOJP, and Gordon Wateridge appears to have resigned. However, within weeks, the Director of Education provided a reference, dated January 1974 and addressed to the Director of Social Services in Oxford. The reference stated that there had been a change of Superintendent at HDLG during the year and that the Wateridges and the new Superintendent "*do not share the same outlook".*[6]

8.15 Mr and Mrs Wateridge were described in the reference as having *"many good qualities and, if given the type of leadership and guidance they at times require, can be an asset to any establishment".*

8.16 The States of Jersey submissions concede that this reference "*was plainly inappropriate*" in the light of the Education Committee resolution of 29 November 1973.

8.17 The submissions by the States of Jersey contain other instances of complaints being responded to with greater or lesser degrees of success. These examples include: (i) the 1972 disclosures made by WN162 about WN121 being taken from his bed; (ii) the 1975 disclosures made about Henry Fleming, a neighbour at HDLG; (iii) an alleged assault in 1976 against WN145

[5] WD001203
[6] WD001203/4–5

that was not initially reported to the Police; (iv) the 1989 disclosures about abuse committed by Les Hughes at Clos des Sables; (v) the 1990 disclosures by staff about the Maguires at Blanche Pierre; and (vi) the 1991 disclosure of allegations about WN335 at Heathfield. Many of these matters are dealt with in more detail later in this chapter. The States of Jersey also dealt with the introduction of multi-agency response to complaints when they were made, initially in respect of non-accidental injuries to children, largely outside of the care context.

Development of policies and procedures

8.18 Until the 1990s, there is no document, protocol or unwritten set of rules, to which our attention has been drawn, that might be said to amount to a system for victims to report abuse.

8.19 Before that, we do also note the formation of Childline in 1986 and that Anton Skinner said in evidence that this continued to be a "*valuable*" outlet in Jersey throughout the period under review.[7] One child who reported allegations of abuse at Clos des Sables in 1989 said that the formation of Childline made her realise that what was happening to her was wrong,[8] but she did not report it to them. However, she did witness another girl making such a report.[9] Some disclosures of historical abuse were initially reported using this service during the late 2000s.[10]

8.20 From 1991, there were Child Protection Guidelines in place,[11] but these focused on procedures for professional and voluntary agencies to report abuse. Furthermore, these do not appear to tackle the abuse of children in care and instead seem to focus on suspected abuse within the family home. In contrast to this, the English "Working Together" guidance of the same year included specific procedures recognising the particular challenges in reporting abuse in residential care, and set out a framework for the reporting of such allegations.

[7] See WD007103/320
[8] WN23 – WD008922
[9] WS000011/10
[10] E.g. WD008867/189
[11] WD009137

8.21 We note that, in 1994, there was, in Jersey, a "Children's Rights and Complaints Procedure",[12] which set out that complaints by children should be dealt with at a local level, but that serious complaints could go to the Children's Officer, who would appoint an Investigating Officer. However, no witness referred to this in evidence and therefore we think it unlikely that this was widely disseminated. In 2002, a "Sexual Misconduct Policy for Children's Service" was published which set out the duty of members of staff to report any suspicion of sexual or physical abuse to the Child Protection Coordinator, who may then refer it to the SOJP's Child Protection Team.[13] By 2004 the Child Protection Committee had published guidance into "allegations against staff" which again focused on the duty of staff to report any complaints of abuse upon receipt (and was largely directed at schools),[14] and the following year, updated child protection procedures were published, which set out basic safeguards to allow for disclosures, including ready access to a trusted adult, readily accessible complaints procedures, and procedures for staff or carers to report concerns of abuse.[15]

8.22 We acknowledge the evidence of Phil Dennett[16] that, although the 2005 Child Protection Procedures applied to everybody, he was fairly certain that there was a much smaller booklet for staff and young people which directed them to talk to the head of the Home, or to go to a Senior Manager, or to the Child Protection Team. We have not seen any such booklets from the time and no child or member of staff who made a complaint refers to any such booklet.

8.23 Despite the above, when concerns were raised with staff at the children's homes, a recurring theme in the evidence is that the children raising the concerns were subject to further or more severe punishment. In some cases, they were beaten, in others they were kept in detention cells. In the very early part of the period under review it is clear that children were sent, entirely inappropriately, for psychiatric assessment and potentially risked detention in a psychiatric hospital if they raised concerns. Some were threatened with being sent to an Approved School in the UK.

[12] WD008546
[13] WD009349
[14] WD009035
[15] WD008591
[16] Day 134/16–17 – in relation to the mid-2000s

8.24 Many witnesses spoke of being disbelieved and simply having had their concerns brushed aside. They were told they were making things up, dismissed as fantasists or the products of damaged upbringing. They were told that the word of a child had no value against that of an adult.

8.25 The culture of each home provides an important context to the reporting (or non-reporting) of abuse. In some homes, the number of alleged abusers deterred some witnesses from speaking out. Former residents said that there was no-one to whom they could turn. Other witnesses say that they disclosed abuse to approachable members of staff but that nothing ever came of it.

8.26 Part of a consideration of Term of Reference 4 is the non-reporting of abuse and any explanation given for not disclosing abuse. This issue implicitly requires consideration under Term of Reference 8 as well – in order to establish what systems were in place for reporting abuse and the adequacy of any such systems, we need to consider the evidence of those who did not report abuse and identify why not. Many said that they did not think that they would be believed or that if they did report their concerns they believed that no action would be taken. This evidence was given in relation to reporting concerns to staff in residential children's homes, child care officers (CCOs) and members of the Honorary Police and SOJP.

8.27 Most of the evidence from witnesses who were children in care, about the reporting of abuse, is to the effect that they did not feel able to report abuse at all, as discussed below. The reasons given are many. Some were frightened to raise concerns and feared further punishment if they did so. Some had been punished and humiliated to such an extent that they lacked the confidence and self-esteem to voice their concerns. Some felt unable to approach those in positions of authority, whether staff members, employees of Children's Services or the Police. They did not think they would be believed. The people to whom they would naturally report abuse were the very people they alleged were abusing them. Some had tried raising their concerns on previous occasions but were punished, disbelieved or humiliated for having done so. The prevailing culture was that children did not speak up.

They were threatened by their alleged abusers with further punishment if they spoke up and/or were told that no one would believe them if they did.

8.28 We note that out of 132 claimants to the Historic Abuse Redress Scheme, 24 reported having complained to Children's Services or residential care staff at the time, 34 made complaints to other third parties, and 74 made no complaint for a variety of reasons.[17]

8.29 A selection of accounts in which abuse was not reported are set out below, although several further examples are contained within our examination of the reporting of abuse on a home-by-home basis later in this chapter.

8.30 WN397, resident at HDLG in the 1960s, described WN515 running over her hand with a hot teaspoon for not sweeping the floor to his satisfaction. Her evidence encapsulates what a number of witnesses said about their reluctance or inability to report alleged abuse while in care. She said:

> *"I did not tell anyone about this. There was no one to tell. Nobody would have listened."*[18]

8.31 WN347 alleged physical abuse by Ray Williams (staff member) after his admission to HDLG in May 1969. He said:

> *"I was fearful of him. The assaults by him towards me were numerous and of a bullying nature. This was the person I would have to speak to if I had a problem, but he was the problem."*[19]

8.32 WN209 described repeated sexual abuse by Ray Williams in the mid-1960s at HDLG. She told no one at the time "*because he told me not to or I would be in trouble … I just did as I was told*".[20] In 2008, when she made her Police statement, WN209 had still not disclosed the alleged abuse to her husband or her sister.[21]

8.33 WN217 alleged that she was raped by a male resident just before she left HDLG in 1980. In her Police interview in 2013, WN217 said that she had only ever spoken to her therapist about the alleged rape. She did not report the

[17] Day 145/52
[18] WS000251/5
[19] WS000153/3
[20] WS000137/5
[21] WS000137/7

incident at the time as she was due to leave the Home and wanted to leave "*with no hassle*". Her assailant had threatened her not to tell anyone and "*the Police never believed a word you said*". She also thought "*my mother would have made mountains out of it and got nowhere".*[22]

8.34 William Dubois moved to La Preference in 1985, and frequently absconded. He said that the Police never asked why he ran away and he did not tell them. He told the Inquiry:

> *"No one listened. We were horrible little brats, we were in care, we got what we deserved."*[23]

8.35 Another recurring complaint was the lack of opportunity for children to make disclosures. Witnesses spoke of infrequent and supervised family visits, infrequent contact with the CCOs or a distant relationship with the CCO. A number complained that when a CCO visited, he or she spoke predominantly with the staff or Houseparents and did not see the child alone.

8.36 Several witnesses said that they did raise concerns at the time but these were not acted upon. Examples include absconding children telling the Police why they ran away from a home but simply being returned to the home without further enquiry.

8.37 Underlying all of the accounts is evidence about the prevailing cultural attitudes of the time. These include how children were viewed in general and those in care in particular, the stigma attached to those from difficult family backgrounds or with a history of offending, the acceptability or otherwise of the use of physical discipline and the deployment of psychological punishments.

8.38 In several cases, reports of abuse were acted upon and steps taken culminating in disciplinary action or prosecution. In other cases, concerns were reported but there was delay before action was taken, thereby potentially exposing more children to allegedly abusive behaviour.

[22] WS000387
[23] Day 62/22

8.39 We set out examples of the evidence on the reporting of abuse on a home by home basis as the ability to report depended, to a significant degree, on the culture prevailing in each of the homes at the relevant time.

Jersey Home for Boys

8.40 Giffard Aubin (1943–1951) said in his witness statement to the Inquiry that the boys knew that if they spoke out they would be punished. Visitors were only allowed once a month and the older boys and staff closely supervised the visits. On the one occasion, Giffard Aubin did speak out to another boy he says he was taken to the General Hospital for assessment for mental illness. The doctor declined to admit Giffard Aubin to St Saviour's.[24]

8.41 WN259 (1945–1954) described an incident where he and a friend went out picking flowers and his friend was taken off into the woods by a former resident at the Home who forced the child to masturbate him. The boys told the Superintendent and the former resident was charged. WN259 and his friend gave evidence and the man was convicted.[25]

8.42 WN190 absconded from the home in 1952, with seven other boys. He said that when picked up by the Police they told officers about the abuse they suffered at the Home and showed them the scars that proved the physical abuse. WN190 said that they were simply returned to the Home and were beaten.[26] He also reported an incident of sexual assault by a former resident, who was staying overnight, and got into his bed and touched his penis and buttocks. He said that he told the Superintendent but that no action was taken.

8.43 WN133 (1950–1955) stated that he and three others went to the Constable's house to complain of a physical assault by one of the staff members. He showed his injuries to the Constable's wife but no further action was taken.[27]

8.44 WN186 (1955–1965). His period of residence spanned the era of the Jersey Home for Boys (JHFB) and HDLG. He stated that from the age of 10 to about

[24] WS000001/8
[25] WS000036/9
[26] WS000046/3
[27] WS000057/11

13 he was the subject of repeated sexual assaults by a Master at the Home. He told the Police in 2008 that the Master told him that if he disclosed the abuse to anyone else he would be punished. In evidence to the Inquiry characteristic of those who suffered alleged sexual abuse WN186 said: "*I did not realise the sexual abuse I was suffering was not normal. I assumed it happened to all of us and it was never spoken about."*

8.45 Winifred Lockhart was a resident in the JHFB from the autumn of 1948. She slept in a bedroom opposite the boys' dormitory and alleged that she would be woken at night to the sound of boys screaming "*Leave me alone, I do not want to go*". She could also hear the voice of a staff member saying words to the effect "*You were all right last night, why not tonight*?" She told the Inquiry that she spoke to one boy but he told her not to say anything. She said that she told a senior member of staff whose response was that no one would believe her. If she did not shut up then she would be sent to a place where no one would find her. Winifred Lockhart was eventually admitted to St Saviour's following these disclosures.[28]

8.46 WN149, a resident at the JHFB, wrote in his Redress Scheme Application, under the heading "Complaints of Abuse":

> *"You did not do this. You were young and did not know what to do and you feared more beatings."*[29]

8.47 Entries in the punishment books over this period suggest that the staff were alive to the risk and indeed the fact of sexual activity between boys and of older boys assaulting younger boys. Despite the entries in the punishment books there are no references in the Committee minutes to reports of abuse between boys at the Home or reports of any abuse alleged against members of staff.

<u>Jersey Home for Girls</u>

8.48 Violet Renouf told the Inquiry that there was no opportunity to speak about treatment at the Jersey Home for Girls (JHFG). There were few visitors to the Home and no one to complain to, neither the Parish Constable nor at the

[28] WS000006/17
[29] WD008715/4

church she attended.[30] In adulthood she spoke to three different doctors about her childhood experiences and was told each time: "*It is in the past.*"[31]

8.49 Winifred Lockhart described a number of attempts to disclose alleged abuse. She said that two staff members were present when WN517 hit the girls and pulled their hair. The staff members did not intervene and when challenged said: "*Our hands are tied.*" Winifred Lockhart told her teacher at school about the alleged sexual abuse by the Home doctor. The teacher said that she believed her, which "*helped a lot*". Nothing was done after this disclosure and there was no follow-up from the school or Social Services.[32]

8.50 WN208 was resident in the JHFG from about 1946/1947. In her Redress Scheme Application in August 2012 she provided a detailed account of sexual abuse. The perpetrator told her not to tell anyone about what had gone on.[33] In her Police statement of 2008 WN208 also said that a staff member told her not to tell anyone what was happening.[34]

<u>Sacré Coeur</u>

8.51 In his Redress Scheme Application, WN156 stated that his older siblings and an aunt complained to the States authorities about the poor treatment of the five children by the nuns. They were moved out of the orphanage to the Boys and Girls Homes respectively. This appears to be a rare example of children being removed from a home following complaints about maltreatment of children by staff.

8.52 WN19 was resident (with her brother) for a period of weeks in both 1958 and 1959. She told the Inquiry that they did not discuss their experiences when they returned home: *"There was no one to talk to in those days. Firstly, they would not believe you and secondly, they would probably give you a beating for making things up."*[35] WN19 indicated that Children's Services were never really involved with her family despite her father being an alcoholic and beating the children.

[30] Day 8/113
[31] Day 8/114
[32] Day 11/49
[33] WS000077/4
[34] WS000076/4
[35] WS000008/4

8.53 WN894 said that she was abused on a visit by Jimmy Savile when she was eight or nine years old. She was selected to give Jimmy Savile a present when he visited the orphanage. When she was left alone in a room with him she said: "*He showed me his penis and took my underwear off and touched me below."* WN894 reported the incident to one of the nuns, who washed out her mouth with soap and told her never to speak to anyone about it.[36]

8.54 WN894 also alleged abuse by the brother of one of the nuns. She said that she reported this to the Mother Superior but was punished by being locked in the dormitory. She told the priest in confession and, notwithstanding supposed confidentiality of confession, the following day she had her mouth washed out with soap by the Mother Superior.[37]

Haut de la Garenne (1959–1969)

8.55 WN124 left the Home in the early 1960s and provided an insight into the alleged regime of abuse and why it was not reported: "*It's your word against the Establishment, so what chance have you got?*"[38]

8.56 WN324 said that a girl at the Home (WN123) told him and some other senior boys that she had been groped by Ray Williams, a member of staff. They told another staff member, WN491, about this. He said that WN123 had made it up and went on to say that Ray Williams might lose his job and that if he, WN491, heard anything more about it they would be for the high jump.[39]

8.57 WN158 alleged that he was sexually assaulted at night on a regular basis until the age of eight. He complained to the Superintendent, Colin Tilbrook, along with three other boys. Colin Tilbrook's response was that they were all "*imagining things*".[40] WN158 absconded from the Home on one occasion and on his return repeated this disclosure to Colin Tilbrook who said that he was being silly.[41]

[36] WS000718/2
[37] WS000718/6
[38] WS000130
[39] WS000145/6
[40] WS000193/6
[41] WS000193/7

8.58 WN220 described sexual assaults by Ray Williams on himself and other boys when they were in the showers.[42] WN220 said that he reported this to Colin Tilbrook who caned him and placed him in one of the detention cells for a long period. He said he was then sexually abused by Colin Tilbrook when in the cells, having been caught in a state of arousal after Colin Tilbrook provided him with a pornographic magazine. WN220 said the abuse stopped abruptly after a period of weeks.

8.59 WN346 told a friend about being sexually assaulted by Ray Williams and the incident was eventually reported to Colin Tilbrook, the Superintendent, by one of the children. Colin Tilbrook took her to his office and told her off for "making up stories". WN346 said she "just clammed up because I was warned and I knew that no one would believe me above Mr Williams".[43] This complaint was recorded contemporaneously – she wrote a seven-page account in a note book detailing what Ray Williams had done, her concerns and the action that she and friends decided to take.[44] The complaint was further set out in a typed memo to Colin Tilbrook from WN491. The memo (1 May 1967) faithfully relays WN346's complaint, describing it as a "rumour", names other residents supporting the complaint and concludes: *"So far I have stopped them from going out this weekend for spreading malicious gossip."*[45] It would appear that the allegation was initially made because a group of children were threatening to tell WN491 about something that Ray Williams had done, and then another member of staff "got to the bottom of the matter".

8.60 WN162 described Colin Tilbrook putting him in a detention room and then sitting on the bed and fondling his genitals.[46] He said that this happened three times between the ages of eight and 10. WN162's evidence highlights the children's perception that they had no-one to whom they could disclose abuse when the alleged abuser was the most senior member of staff: *"Who could I tell? He was in charge of the Home.*" His CCO at the time was Jim Thomson (later to become Superintendent of the Home): "*The only person who could help me was Mr Thomson and he did not care.*"

[42] WD000185/11
[43] WS000152/6
[44] WD006639/7
[45] WD006639/8
[46] WS000272/8

8.61 WN184 said that he was a frequent absconder and told the Police that he did not want to return to HDLG. There is no suggestion that the Police questioned why he did not want to go back to HDLG. He said that on his return he was caned and put in the detention room.[47] He told the Police in interview in 2008 that those who hit him never left any marks or bruises. He said that HDLG was ruled with fear.[48]

8.62 WN356 said[49] that, on one occasion, Colin Tilbrook touched her breast and genitals when she was using the payphone at the Home. In relation to the reporting of alleged abuse she said: *"I learnt not to complain at an early age, simply because it just did no good, you were told to 'just go away' and 'do not talk rubbish', however this attitude was not just limited to the staff at the Home*". She said that she told Patricia Thornton about the payphone incident, to which she was asked whether there were any witnesses. WN356 thought that other girls also disclosed things that happened to them, but nothing further happened.

8.63 WN512, a former member of staff at the Home, said that no-one reported to her any incidents of sexual or physical abuse; she feels that children did have opportunities to talk to her and to tell her if there was anything wrong. She remembers that she "*reported abuse if it was happening*" but gave no specific incidents. There were no members of staff or children that she was concerned about in relation to sexual abuse: "*I would have mentioned it if I had.*" She says she would have gone to Colin Tilbrook and taken it further if nothing then occurred.[50]

8.64 An individual employed in the nursery and at nights in the 1960s said that she had not been aware of any form of abuse taking place when she worked at HDLG nor was she aware of any rumours. Had she been she would have reported these to the Police.[51]

8.65 WN172, a former resident, alleged that in the early 1960s he was repeatedly raped by Senator Krichefski, who visited the Home. When he was 18 he was

[47] WS000135/3
[48] WS000135/8
[49] WS000204/4
[50] WD006791
[51] WD006639

seen at the Home by Dr Fogarty, consultant psychiatrist, to whom he disclosed the sexual abuse. Dr Fogarty told him not to say any more and went off to get another doctor, Dr Evans. WN172 was sectioned and sent to St Saviour's psychiatric hospital. At the hospital he was seen by Dr Wishart who, he said, told him that he had been admitted because of his fantasies about Senator Krichefski.

8.66 In July 1966, a child was admitted to HDLG while facing charges of "being destitute". While there, he made allegations of serious sexual abuse against Jeff Le Marquand and another person (neither of whom worked at the Home). It would appear that these allegations were reported to the Police by WN491, a staff member.[52]

Haut de la Garenne (1970–1986)

8.67 WN324 went to HDLG in 1969. He told WN491 (a member of staff, in the absence of Colin Tilbrook) that he had been beaten up in the showers by a member of staff. WN491 said that he did not believe him and told him to wait outside the office. He waited for over four hours before giving up. "*From that experience I decided not to bother reporting anything else.*"[53]

8.68 WN74 (1971–1976) told the Inquiry about his experience of disclosing abuse to the Superintendent, Colin Tilbrook. He complained about abuse three times and in one instance asked Colin Tilbrook to involve the Police because Gordon Wateridge hit him. The Police were not called and WN74 felt that he never had a fair hearing from the Superintendent: "*Whatever (Wateridge) said would be believed and whatever I said would not.*"[54] He said the children gave up making complaints because there was no point. He was "*pretty sure*" that Gordon Wateridge was violent in front of other staff members.[55] WN170 told the Inquiry that Gordon Wateridge did hit children in front of staff and on one occasion, he was hit by Gordon Wateridge in front of a male staff member, WN515.[56]

[52] WD006341; WD006419
[53] WS000094/4
[54] Day 44/23
[55] Day 44/39
[56] Day 46/20

8.69 In his Redress Scheme Application, WN121 stated that he was physically and sexually abused by Gordon Wateridge. He said that he reported the abuse to Colin Tilbrook who *"said to me that I was a fantasist and a child criminal and if I told anyone else they would not believe me. I took a beating and never tried to make a complaint again after that".*[57]

8.70 The same witness said that he was abducted from the dormitory and raped by WN973, a visitor to HDLG. Despite WN121 saying that he never tried to make a complaint again, this was reported contemporaneously after member of staff called the Police, and WN973 was convicted of the abduction in January 1973[58] (but not the alleged rape, an offence which at that time would have required, as a matter of law, independent corroboration). This would have been after any complaint about Gordon Wateridge. WN121 describes being locked in the detention rooms for two weeks (either after the incident or the trial – the statement is unclear) so that he could not tell the other children.[59]

8.71 WN395 is the mother of a former resident of HDLG. She told the Police in 2008 that, in 1973, her daughter had disclosed to her that she had been sexually abused. WN395 complained to the Superintendent (Colin Tilbrook) who she alleged said that her daughter must be lying and nobody at the home was capable of such things.[60]

8.72 WN125 told the Inquiry that he reported to Mr Thomson that a female staff member, WN277, had tried to entice him and another boy to have sex with her. This only resulted in her "*being spoken to*".[61]

8.73 One former female resident told the Police, in interview in 2007, that WN520 would wake her up in the morning and place his hands between her legs and put his fingers inside her. She believed it started before she was nine years old and *"he would say to me that it was our secret and it was all right*". She used to visit her mother at weekends and stay overnight, insisting that she wore her pants in bed at night. She thought that this was when she disclosed

[57] WD000678/14
[58] Day 37/141
[59] WD000678/15
[60] Day 48/8; WD003465
[61] Day 43/15

the abuse to her mother who then went to see the Superintendent, Mr Thomson. Her account merits reciting in full:

> *"Mum told me that she went up to Haut de la Garenne to speak to Mr Thomson, who was head of the Home and they came to an agreement. She was not supposed to get the Police involved or they would cut her visits down to see us. After my mum went to see Mr Thomson I was bullied by [WN520 and his wife] for two weeks, just verbal abuse all of the time. After it all came out they called me a liar although I cannot actually remember what they said to me".*[62]

8.74 WN50 corroborated the allegations that WN520 abused the child in question. In her statement to the Inquiry she said that the girl's mother complained to Jim Thomson. He dismissed her complaint, saying that she was an alcoholic and if she raised another complaint she would not see her children again. WN50 recalled that WN520 was sent to a children's home in England after this.[63]

8.75 WN520 himself said that the allegation was raised at the time and that as a result, WN715 referred the matter to Charles Smith. Charles Smith then carried out an enquiry, which led to him being exonerated.[64] WN715 cannot remember this happening, adding: "*I have never referred an allegation of this type to Charles Smith or the committee. Any serious matter like this would have been referred upwards by me, I would not have dealt with any allegation of this sort*". [65] The Inquiry does not have any contemporaneous records of the allegation being made nor of any investigation being carried out.

8.76 WN382 (1976 – 1983) said in his witness statement to the Inquiry that two residents told him that they had been sexually abused by another resident, WN43. The allegations were so serious that WN382 told a member of staff. This resulted in WN43 being segregated from the rest of the children at night.[66]

[62] WS000191/3
[63] WS000343/7
[64] WD006939
[65] WD006781
[66] WS000643/5

8.77 In 1975, WN98's mother saw bruising on her child's arms and reported this to the staff at the Home and to the CCO, Richard Davenport. This account is recorded contemporaneously in a memo from WN532 to Charles Smith.[67]

8.78 WN187 (1979–1984) told his brother that he was being abused by Terence Jarrett, the father of one of his friends. The brother told staff member WN515 who reported this to the Police. The prosecution of Terence Jarrett followed.[68] During his time at HDLG, WN187 was the victim of sexual abuse by at least three different men (Terence Jarrett, Thomas Hamon and Tony Watton). He only complained at the time about the abuse by Terence Jarrett. He told the Inquiry that the reason he did not disclose the other offences was that he could not go through again what he had had to go through with the prosecution of Terence Jarrett.

8.79 In 1977, WN503 (a member of staff) reported to Jim Thomson that an incident had taken place between her and WN127. The contemporaneous memo to Charles Smith notes that WN503 struck WN127 in the face "*automatically in self-defence"* and that WN127's mother had alleged that her child had suffered hearing damage as a result.[69]

8.80 Marion Robson, a former staff member, said that there was no procedure in place to make staff feel confident about expressing disapproval. Had she wanted to raise concerns she says she would have done so with the senior member of the group if there had been something "*very extreme*" she would have reported it to a senior member of staff.[70] She would not herself have come forward for fear of not being believed, "*there just was not the culture of addressing those issues like that at the time … there did not seem policies of procedures in place to support anyone who wanted to complain*".[71] She added that if a child had made a complaint to her she would have believed them and would have tried to do something about it.[72]

[67] WD002687
[68] WD004366/5
[69] WD005961
[70] Day 76/454
[71] Day 76/74
[72] Day 76/72–74

8.81 WN287 said that she was not aware of any abuse during the short time she was at the Home, but said that had she seen anything that made her feel uncomfortable "*I would have reported immediately to the head of the Home, WN870*". She told the Inquiry: *"I learnt during my training in England that it was an important part of my duty of care to report any behaviour that caused me concern. That said, there was no established procedure to follow if we did have any concerns, and I did not receive any training in what to do if I did see any inappropriate behaviour. However, it was a matter of using common sense; you simply would not allow a child to be abused … we would not have tolerated any physical or emotional abuse of children at HDLG".*[73]

8.82 Fay Buesnel remembers that she spoke to Jim Thomson about the Jordans and others: "*Occasionally I would speak to him about people I felt that were a bit harsh and perhaps if one person you know just ... maybe hit somebody with a spoon at the table or something and you felt that that was unnecessary, you would speak to them at the time and say 'Do not do that again or I will report you' … I did not put it on paper. You would go ... it was very much ... I would say to him you know I'm a bit concerned about such and such and he would say well you know why have you spoken to the person and I'd say yes and how I dealt with it. And you know Jim was lovely but Jim was very ... [he] hated confrontation of any kind ...".*[74]

8.83 When Mario Lundy was at HDLG in 1985, he said that there was no formal process in place to enable the children there to raise any concerns: *"so it would have been probably children going to a member of staff that they trusted".*[75]

8.84 Many witnesses spoke of disclosing physical abuse by Tony and/or Morag Jordan. A sample of that evidence is as follows:

8.85 WN591 said that attempts to disclose assaults were met with comments such as "*Do not be so stupid*". Staff member WN661 confirmed that she witnessed Tony Jordan hitting WN591 at the dinner table with the back of a spoon. After the children left she told him that she never wanted to see him do that to a

[73] WS000594/5
[74] WD006918
[75] Day74/193

child again. She could not recall whether she reported the incident to the Superintendent. She dated this to about 1984.[76] Tony Jordan was charged and found guilty of assaulting WN591.[77]

8.86 WN191 said that she told Jim Thomson about a specific incident in 1979 when Morag Jordan hit her on the back with a wooden clog, causing significant bruising. Jim Thomson did nothing about it. WN191 said that Morag Jordan and Jim Thomson "*were very close and did not want anything getting out about abuse*".[78]

8.87 WN192 confirmed that Jim Thomson would not believe the children when they told him how they were treated. He would not talk to them. He said that Jim Thomson was always drunk and "*You could never get a sensible word out of him*".[79]

8.88 There is, unusually, a contemporaneous entry from Morag Jordan confirming that she gave WN19 "*a light smack*" on 8 June 1979 because she misbehaved. The incident was followed up by the CCO who appears to have spoken to WN19 on her own.[80]

8.89 Tina McGuire told the Inquiry that she was picked on by Morag Jordan from the time she arrived at HDLG. She said that she was reluctant to share her concerns with the CCO, Pauline Vautier, because she spent long periods of time with Morag Jordan. She did not trust the CCO and thought that whatever she said would get back to the staff. A female staff member, WN14, would try to protect her, but no other member of staff listened to WN14's concerns because she was so junior.

8.90 A significant number of assaults committed by the Jordans are said to have been witnessed by other staff members. There are some examples of the staff taking action but the preponderance of the evidence is that the staff did not intervene.

[76] Day 43/31; WD002306
[77] Day 43/34
[78] WS000305/2
[79] WS000326/6
[80] WD002546

8.91 Marion Robson thought that Morag Jordan was tolerated at the time because "*reporting procedures were much more vague ... there was less guardianship over that sort of thing ... it was a different climate really"*.[81] Ernest Mallett said that he witnessed one episode of the Jordans being aggressive to a child – he intervened and says he was thanked by Jim Thomson.[82] A Housemother [1970–1974] remembers seeing Morag Jordan slam a sliding van door onto a 10-year-old boy's hand, saying as she did so *"That'll teach you"*. She told the Police that she did not report this to anyone at the time because Morag Jordan was her senior.[83]

8.92 WN562 says that she confronted Morag Jordan about her giving a black eye to a child and went to see Colin Tilbrook.[84] A contemporaneous record shows her complaining to Colin Tilbrook about the disciplining of WN38, but notes that "*staff here will continue to discipline him as normal".*[85] She also said that a male member of staff touched her up in a car, but when she reported it the man turned on her and she was told off by Colin Tilbrook.[86]

8.93 WN661 remembers one time when Tony Jordan hit a child on the back of the hand with a spoon. She says that she spoke to him afterwards telling him that she never wanted to see him do that to a child again. She adds: "*I cannot remember if I reported the matter to the Superintendent but I never saw Tony hit a child again whilst I was there.*" She thinks this happened towards 1984. She never saw bruises on children except on one child when she was bathing him on admission to the Home. She remembers reporting that.[87]

8.94 WN704 recalled Tony Jordan picking up WN125 from the floor by the scruff of the neck and letting him go so that he fell to the floor. She confronted him and "*Tony shrugged … saying something like he should be playing with children his own age".* She told WN706, another member of staff, the next day. She

[81] Day 76/102
[82] WS000602
[83] WD006016
[84] WD006933
[85] WD003133
[86] WD006933
[87] WD006777

also told Fay Buesnel. She believes that Tony Jordan got moved from Claymore to Baintree as a result of this.[88]

8.95 WN28, a former resident, said that Morag Jordan hit him on a regular basis and described the abuse as "*rampant and so common*".[89] One staff member tried to protect him and made sure that Morag Jordan was not left alone with WN28 and his siblings. He said that he wanted to confide in that staff member but was scared that if he did she might get into trouble and so also might he.[90]

8.96 WN176 described Morag Jordan being violent in front of the other staff who never said or did anything. He told the Inquiry: *"… The Morag Jordan situation, I would have gone to a member of staff if I would have known something would be done about it, but because we knew nothing would be done about it you are not going to put yourself at risk in that situation for no reason whatsoever"*.[91]

8.97 Some allegations against the Jordans are corroborated by contemporaneous medical records, such as WN125's arm injury, which he alleged was caused by Tony Jordan, and was documented in his medical records, demonstrating contemporaneous disclosures.

8.98 WN99 (resident from 1970) stated that he only ever saw his CCO, Richard Davenport, when he ran away from the home back to his mother. Richard Davenport took him straight back to HDLG where he was placed in detention. He said that Richard Davenport would not listen to anything he said, including complaints he made.[92]

8.99 WN217 said in her Police interview that in the late 1970s she disclosed to Charles Smith, Children's Officer, physical abuse by a female member of staff. When she returned to the Home the female staff member screamed and

[88] WD006776/4–5
[89] Day 43/42
[90] Day 43/58
[91] Day 51/47
[92] WS000368/9

shouted at her "*Never do that again*". She said that she was locked in detention for three days for having made the disclosure to Charles Smith.[93]

8.100 When WN33 was in care at HDLG in 1982, a fellow resident reported to staff that WN33 had consensual sex with a boy from outside the Home. She says that this was after she had been raped by her adopted father on a visit to the family home. Following this report, she was taken to the Police station and examined by a Police doctor, accompanied by a female member of staff from HDLG. The Police doctor concluded that this was not the first time she had had sex. And after "*a long time and a lot of thought",* she told the Police officers that she had been abused by her adopted father. She said that she was disbelieved by the Police and that, following her disclosures and a contemporaneous witness statement, she withdrew her allegations because the Police officers were not supporting her at all, and she was tired – so, in the end, said that she had lied.[94]

8.101 WN48 alleges that he complained of abuse at the hands of WN7 to the Police in 1980, but says that it was never followed up. He says he complained to two officers and they wrote down his complaints and came back to him, saying something like "*we've spoken to him and it never happened".*[95] During Operation Rectangle, WN48 made attempts to get hold of the statement that he allegedly made in 1980, but was told that there was no record of it.[96]

8.102 We have also received evidence about the reporting of peer-on-peer abuse. There are various memos in the late 1970s recording allegations of abuse against Michael Aubin. Some of these appear to have arisen as a result of a resident at the Home disclosing this abuse (either to a fellow resident or a member of staff),[97] whereas others arose when the incidents were seen by members of staff.[98] Contemporaneous allegations were also made by residents about WN43.[99]

[93] WS000387/20
[94] Day 48
[95] WS000406
[96] See, for example, WD003514/31
[97] E.g. WD00 2938; WD001465;
[98] E.g. WD001444;
[99] WD000977

Heathfield

8.103 WN36 alleged that after he left Heathfield he was sexually abused by WN637, who had previously been his key worker at HDLG and Heathfield. Contemporaneous records show that WN36 reported the incident to the SOJP at the time. WN637 was interviewed and admitted that sexual contact taken place but said that WN36 was a willing partner.[100] The matter was not pursued by the Police on the basis that WN36 had not made a formal complaint. After reporting the incident to the Police WN36 recalls that he met with his CCO who "*actively persuaded*" him not to take the matter any further.[101]

8.104 WN216 alleged that he was sexually abused by WN335 over the course of a number of years when a resident at Heathfield and after he left the Home. In a Police statement in 1991, he said that WN335 was aware that he was "*vulnerable and insecure and he also knew that I would not be able to say anything to anyone*".[102] His decision eventually to disclose the abuse that he suffered was because he was concerned that another resident at Heathfield was at risk of sexual abuse by WN335. He therefore reported the matter to several members of Heathfield staff including WN92, WN937 and WN655.[103]

8.105 Darren Picot alleged that WN335 attempted to abuse him sexually while he was resident at Heathfield. On a few occasions, he took him into his office, locked the door and touched him inappropriately. On one occasion, Darren Picot almost reported this to a member of staff but he was "*on edge and worried*" and did not tell him.[104]

8.106 Darren Picot gave evidence that he told Richard Davenport that WN335 said he was being sexually abused WN216. This was recorded by Mr Davenport at the time (after WN216 had already made disclosures), and it is noted that Mr Davenport replied with "gentle questioning" about Mr Picot himself, to which he denied that he had "*ever been approached either verbally or physically by*

[100] WD002284/74
[101] WS000479/118
[102] WS000486/3
[103] WS000486/9
[104] WD000201/14

either party in a sexual way".[105] Mr Picot told the Inquiry that he denied this at the time because he did not want it hanging over his head.[106]

8.107 WN80 alleged that he witnessed WN335 lying naked on top of WN216 in one of the bedrooms at Heathfield. He said that he reported this to WN790, a member of staff, who said he "*must not say things like that*".[107]

8.108 In 2000, a resident at Heathfield alleged that he had been assaulted by WN819, which led to investigations by the Police and by Children's Services. The resident had disclosed this allegation to his father, who then passed it on to Children's Services.[108]

8.109 In 2001, WN698 made a complaint of physical assault against two staff members, WN166 and another member of staff. The staff members in turn alleged assault by WN698. Children's Services held a strategy meeting attended by senior staff as well as the Police.[109]

8.110 WN752 was sexually abused by 60-year-old Roger Hatte when she was resident at Heathfield in 2003. He was convicted of one count of unlawful sexual intercourse. She alleged abuse over a number of years and said that after the last occasion, on 30 December 200,3 she made a disclosure to her key worker WN753.[110] The Police report notes that there had been "*previous reports of an unhealthy association between WN752 and the accused for a number of years, but in the past there has been insufficient evidence to support investigations and prosecutions*"".[111]

8.111 WN752 made a further disclosure, after she left Heathfield, of a sexual relationship she had with her former key worker, WN753. She disclosed this by telephone to a member of the Leaving Care Team. This led to WN753's resignation after he admitted the relationship.[112]

[105] WD000201/28
[106] Day 25/156
[107] WS0004535
[108] WD006092
[109] WD006831
[110] WS000495/4
[111] WD004899/1
[112] WD006395

8.112 In 2004, a member of staff at Heathfield spoke to Ann Shine (CCO) about a disclosure he had received by WN619 with various allegations against WN7, including that she had witnessed him assaulting WN618 at La Preference. Ms Shine notes that they would discuss the information with the SOJP Family Protection Team and it would likely be considered within the ongoing investigation into WN7, arising from complaints made by WN749 at La Preference. [113] WN619 later decided that she did not wish to make a complaint.

8.113 In 2006, an allegation was made that a female resident was forced to perform oral sex on WN820, a member of staff. The disclosure was made initially to a fellow resident who told the other children and a staff member. The complainant was interviewed by her CCO and staff at the Home. She confirmed that the allegation was true following which the matter was reported to the Police.[114]

8.114 In 2008, two members of staff reported to their manager that the Manager of the Home, Kevin Parr Burman, had used excessive force when taking hold of a vulnerable resident, WN823. This allegation was then passed on to the SOJP's Public Protection Unit (PPU) to investigate.[115]

8.115 In 2009, further allegations of physical assault were made against WN819, by a different resident. This led to an investigation by the SOJP and a subsequent internal investigation by Children's Services, as discussed in Chapter 9.

La Preference: a Private/Voluntary Home

8.116 WN205 made allegations of abuse against WN755 and Edward Paisnel. WN755 was related to one of the members of staff and WN205 alleges that he touched her inappropriately in the genital area while the children watched television in the dark. Mr Paisnel was a regular visitor to the Home. He would get the children to sit on his knee and touch the girls in the genital area.

[113] WD009342
[114] WD006877/1
[115] WD006059

WN205 said that she said nothing because she did not feel that she would be believed and all of her abusers were closely connected to one another.[116]

8.117 WN214 complained of sexual assault by three boys at the Home. She also said that she often woke on a Saturday night to find herself being sexually assaulted by another male.[117] She told the school nurse, who then telephoned the Home. She said that a staff member told her that she was a liar and would never fit in anywhere. WN533 verbally abused her, telling her that she was making up lies.[118]

8.118 However, in 1979, WN214's sister, WN45, disclosed to WN729 that both of them had been sexually assaulted by Roger Horobin between 1976 and 1978. WN729, a staff member at La Preference, immediately told Charles Smith (CO) who informed the Police, eventually leading to Roger Horobin's conviction.[119]

La Preference: run by the States of Jersey

8.119 In 1992, a complaint was made by a child's father that Ernest Mallett had physically assaulted the child on several occasions at La Preference. [120] This led to a disciplinary hearing.

8.120 Around 1996, a child made disclosures to Fay Buesnel (OIC) that she had been sexually abused by an associate of her mother's a few months beforehand. According to the note, Fay Buesnel told the child that she would need to pass this information on and it was then passed to Marnie Baudains and on to Selina Larkin.[121]

8.121 In 2000, further allegations of physical assault were made against Ernest Mallett – information was passed swiftly by WN687 (Manager of La Preference) to the Manager of Children's Services.[122]

[116] WD003834/4
[117] WD000670
[118] WD000670
[119] WD007346/14
[120] WD006573/15 is a copy of the complaint
[121] WD008625
[122] WD006573/30

8.122 In May 2003, WN73 met WN687 ahead of his pending placement at La Preference. During this meeting, WN73 disclosed his concerns regarding the treatment of the children either attending or remanded at Les Chênes.[123] These included actions by WN654 and another member of staff against various residents, as well as issues about being locked in solitary confinement for long periods.[124] The allegations against WN654 referred to striking a child on the head, grabbing/restraining another child by the testicles and restraining the same child and banging his head on the floor. There was also an allegation that he had exposed himself in the shower room. Following the disclosure, WN687 reported the matter to Phil Dennett, who in turn forwarded the complaints to the SOJP's Family Protection Team (FPT) via Sarah Brace of Children's Services. It was noted that "*the Police and children's service know all the alleged victims in this inquiry … they are all troubled young men and regular attendees at Les Chênes".*[125] As part of the SOJP investigation, other residents of Les Chênes also made disclosures.[126]

8.123 In 2003, WN617 wrote to Marnie Baudains, alleging that he had been assaulted by WN7 at La Preference in the early 1980s. This prompted an internal investigation, including a meeting with WN617 and an interview with WN7.[127] WN617 had initially contacted the SOJP FPT and was directed to Children's Services.

8.124 In 2004, allegations were made by both WN618 and WN749 that they had been physically assaulted by WN7 at La Preference over the previous 18 months.[128] These allegations were first disclosed by the children to a CCO (and a member of staff at Heathfield, as above) and then a formal complaint was made to the SOJP.

8.125 In August 2010, a resident at La Preference alleged that he had been physically assaulted by Kevin Parr-Burman, who had previously been the subject of allegations at Heathfield. This was subsequently investigated by the

[123] WD005740
[124] WD003947
[125] WD005740/3
[126] WD006418/8–21
[127] WD003848; WD003849; WD003850
[128] WD009342

SOJP[129] and then internally. We note that while Kevin Parr-Burman was Manager of La Preference, he had previously set out a guide to completing incident reports, which included guidance in how to respond to any allegation of abuse.[130]

8.126 Email correspondence between Phil Dennett, (Co-ordinator (Children's Executive)) and Joe Kennedy (Manager of Residential Services) from February 2011 records a complaint from a female resident about a male resident exposing himself to her and touching her up inappropriately. She also alleged that she had been touched up by another male resident at the Home. It is not clear from the documentation held by the Inquiry how this complaint was dealt with.

Brig-y-Don: run by the States of Jersey

8.127 An incident recorded on 15 May 2013 described a male resident complaining of being tipped out of bed by two male staff members and being restrained with excessive force. The Police attended and handcuffed the boy because he was shouting and screaming. The record does not deal with this incident as a complaint by the boy.

8.128 On 9 December 2013, a court-appointed psychologist, Christine Tizzard, contacted the Head of Children's Social Work, Sean Pontin, to make a disclosure of alleged physical and sexual abuse of residents by staff of Brig-y-Don (BYD). She described the position as extremely concerning and said that it required investigation:

> *"My office have so far this morning been directed to make several calls to different numbers without success in order to make a disclosure. I have now been advised the most effective manner is to contact you by email."*[131]

Les Chênes

8.129 WN620 was a resident at Les Chênes between 1981 and 1984. He stated he was physically abused by a number of staff including Mario Lundy, WN246 and WN110. When he threatened to report incidents of physical abuse to his

[129] After having been passed on by the child's Social Worker – WD009059/25
[130] WD009229
[131] WS009045

father he was told by WN108 that "*whatever happened in these four walls stayed there".*[132] WN620 stated that he did not make a complaint at the time because he had been told not to and in any event, he did not know how to go about making a complaint.*[133]* This is an example of a former resident mentioning the lack of a formal reporting system being an impediment to making disclosure. We do note that a complaint was eventually made to the Police about physical abuse in December 1999.

8.130 WN145 was at Les Chênes between 1981 and 1984 and alleged physical abuse by WN108, Mario Lundy and WN246. He stated:

> *"No one ever spoke out about the abuse at Les Chênes. I did not feel that there was anyone we could speak to. We did not see our Child Care Officer on a regular basis … I remember one resident did speak to his parents about the abuse. The parents came in to raise their concerns … But as soon as his parents left [he] was beaten black and blue again by WN108 and WN246. That is what happened if you dare to speak out."*[134]

8.131 WN673 was admitted to Les Chênes between 1980 and 1984 and alleged physical abuse by Mario Lundy and WN246. He said:

> *"I could not tell anyone at the home about the violence that was going on because there was no one to tell … I never told my mum because she would have been upset and will probably have kicked off with the staff. All the children at Les Chênes trusted each other, but we knew not to trust anyone else."*[135]

8.132 WN621 was admitted to Les Chênes on remand around 1984. She says she witnessed WN69 being punched in the face by WN246. When she and WN69 were taken to their weekly remand hearing before the Magistrate, they disclosed this incident to him. WN621 stated that the Magistrate said WN69 must have deserved it and that his response "*gave (her) no confidence in telling anybody in authority about anything that had happened to me or anybody else. There was no one to tell*".[136]

8.133 William Dubois resided at Les Chênes for short periods while on leave from boarding school in around 1988. He says he was abused by Mario Lundy and

[132] WS000457/2
[133] WS000457/3
[134] WS000500/5
[135] WS000498/9
[136] WS000438/4

another staff member. He told the Inquiry that he disclosed the abuse to which he had been subjected to his CCO, Dorothy Inglis, but that she would "*bury her head in the sand*".[137] In evidence, she replied saying that she spent a great deal of time with him and he did not tell her about any abuse he suffered.[138]

8.134 Mario Lundy told the Inquiry that there was no formal complaints process while he was Principal. He said that in retrospect perhaps there should have been but added "*I would be surprised if you found something like that in any similar school elsewhere at the time … it could have been much more effective*".[139]

8.135 When asked whether the scale of Les Chênes was conducive to making complaints, Mario Lundy suggested that people were coming in and out of the school every day: "*Social workers visited, social workers often visited young people away from Les Chênes which gave them the opportunity obviously to speak more freely but there was also a confidential counsellor who attended the school.*"[140]

8.136 He said that had a child wanted to make a complaint, he would have them speak to either their parents, their social worker, their probation officer, the school counsellor or the educational psychologist. He said that there were not many occasions when parents complained to him about the treatment their child said they had received.[141] The opportunity to see parents was not limited to home leave as parents could come on Sunday afternoons and stay "*for as long as they chose to stay*".

8.137 Mario Lundy recognised that both the educational psychologist and the clinical psychologist's function at Les Chênes was to assess rather than provide any therapeutic provision. He would not be drawn on whether in those circumstances it would have been realistic for a child to have made any disclosure. He did not think that the CCO would be the first port of call for a child at Les Chênes who wanted to speak to someone outside of the school.

[137] Day 62/39
[138] WS000629/28
[139] Day 74/52
[140] Day 74/54
[141] Day 74/56

8.138 WN834 could not recall any allegation of abuse being made against a member of staff although "*pupils would complain if they perceived an injustice*". Any complaint about the unfairness of the actions of a member of staff would be investigated by WN834. This happened rarely and that she had regular access to an external advisor if she was concerned about any issue in the school that she did not wish to discuss "*internally*".[142]

8.139 WN834 did remember dealing with an allegation that an older boy had tried to touch a younger boy's genitals in the shower. She says that she was called to Mario Lundy's office to hear the complaint and to ensure that a written record existed before Mario Lundy asked the older boy about the allegations. The social workers of both boys were contacted, a risk assessment was carried out and a plan put into place.

8.140 WN698, admitted around 2000, states that she complained about alleged physical abuse at Les Chênes to her CCO, Stuart Hallam.[143] In March 2003, WN698 complained to the Police that she had been assaulted by WN543 while being restrained by him. This led to a Police investigation, including a medical report on WN698's injuries.[144]

8.141 WN629 was resident at Les Chênes around 2001. She said that she saw WN543 holding a student by the neck against a wall. She reported this incident to her mother and a complaint was made to the school but nothing was ever done.[145] WN629 also complained to WN543 and WN245 about staff member WN544, saying that he would come into the girls' bedroom and watch as she and WN698 were getting changed. She said that nothing ever happened as a consequence of this complaint.[146] In 2002, WN629 disclosed to WN543 that she and WN698, had been the victims of rape while they were both students, though not residents, at Les Chênes. This matter was reported by staff at Les Chênes to the Police the next day.[147] This disclosure was made following an altercation referred to above in which WN698 assaulted

[142] WS000719
[143] WS000511/8
[144] WD005115
[145] WS000449/4
[146] WS000449/5
[147] WD003976

WN543 (and in relation to which she was subsequently convicted of common assault).[148]

8.142 In 2001, Les Chênes staff requested Police assistance to deal with a resident, WN761. When the Police arrived, two staff members, WN245 and WN543, alleged that WN761 had assaulted them. While WN761 was being interviewed by the Police, he raised concerns about the staff treatment of a fellow resident, who was his girlfriend. WN761 subsequently made a counter allegation of assault to the Police against WN245 and WN543, after having absconded and told his mother. An SOJP investigation ensued, in which the Police investigated the possibility of more widespread abuse.[149] Ultimately, there were no prosecutions, but the Police report eventually led the Director of Education to commission the first Dr Kathie Bull Report.[150]

9.143 WN630 was admitted to Les Chênes between 2001 and 2003 following the commission of a criminal offence. He said that he was placed in a headlock by staff member WN110 and that this was reported to the Police at the time by WN777. He did not pursue the complaint further as he was still at Les Chênes. WN630 said that he did complain to his father about being placed in the secure unit for a prolonged period of time. His father "*complained to the authorities but it got him nowhere*".[151]

8.144 WN73 was resident at Les Chênes and Greenfields between 2002 and 2005. He said, of the use of the secure suites:

> *"There really was nothing I could do about my treatment and being placed in solitary for long periods of time. The problem was that there was nobody for children to complain to .... We could not have approached [certain members of staff] and if we did they would not have listened. We could not complain to the Police because they were putting us in there."*[152]

[148] WD005109
[149] WD008345/106–120
[150] Day 113/71–3, WS000652/24–25
[151] WS000450
[152] WS000443/23

8.145 As set out above, we note that it was only when WN73 left Les Chênes to go to La Preference in 2003 that he felt able to make disclosures about abuse at Les Chênes.[153]

Family Group Homes

8.146 The response to allegations of abuse in the FGHs is addressed in detail in Chapter 9. For present purposes, it is important to note the following with regard to the reporting of abuse.

Family Group Home run by WN279 and WN281

8.147 WN45 gave evidence that her teacher saw bruises she had developed as a result of beatings from WN279. She says she was taken to see the head teacher and says: *"The headmistress asked me how I got the injuries but I would not say. I begged and pleaded with her not to tell anyone because I knew I would get another beating if WN279 and WN281 found out … This was at my secondary school, St Helier's Girls School."*[154]

8.148 WN45 also says that she complained about an inappropriate visiting clergyman to WN279, and WN279 stopped the children from going to his church.[155] WN45 says that she only told two friends about the alleged physical abuse perpetrated by WN281 and WN279.[156]

8.149 There are contemporaneous records from February 1975, which show that WN319 complained to his teacher at St Luke's School that WN279 had hit him, causing a bruise on his head. The teacher reported it to the CCO, Ms Hogan, who attended the school to speak to the teachers and children. Teachers reported that the children had often talked of being hit on the head.[157]

8.150 WN287, a staff member at the Home, gave evidence that WN319 told her on a different occasion that the bruise above his left eye had been caused by WN279 "*in the bathroom".* WN287 said that she reported the incident to

[153] WD006418/9
[154] WS000168/6
[155] WS000168/13
[156] WS000168
[157] WD009278/23

Brenda Chappell (SCCO) and that there was then a meeting, eventually leading to WN279 retiring about three months later.[158]

8.151 WN319 provided a statement in which he said that WN279 gave him a black eye by pushing him into a bath tub. He recalls that that Charles Smith attended the Home a couple of days later to speak to him, as well as two people from the Foster Parents Association. He says that he told them about the bath incident, and shortly after this WN279 and WN281 left the Home.[159] Although we cannot be certain, it would seem that this is likely to be the same incident referred to by WN287.

Clos des Sables

8.152 In 1968, WN347 disclosed to Les and Janet Hughes that he had been sexually abused while at school in the UK, before arriving at the FGH. This is recorded in the Houseparents' Report to Children's Services, along with their view that the story was made up to win sympathy.[160]

8.153 WN148 says that she walked in on Les Hughes assaulting WN23 one night; she told a staff member, WN283, about the abuse of WN23 but was promptly asked to leave the Home by Janet Hughes.[161] WN148 told the Panel that she did not think WN283 could comprehend that Les Hughes might sexually abuse her, as she was a very loving and trusting person.[162] WN148 explained to the Inquiry that she did not feel able to tell anyone about the abuse before that, saying that she had learned that nothing would get done about it, no one would listen if she tried, there was no one to talk to, and that as a child, they did not feel comfortable saying anything to those who did visit.

8.154 WN282 also alleges that she disclosed sexual abuse by Les Hughes to WN283, but she was very reluctant to do anything about it. She alleges that WN283 replied by saying: *"think about Ms Hughes, how would she feel? Do not you think she knows what is going on? Of course she does! All this could*

[158] Day 76 and WS000594
[159] WS000171/4
[160] WD001974/17
[161] WS000083/8
[162] Day 21/55

break up their marriage!! Just think about her feelings".[163] She says that she and three other girls mentioned sexual abuse by Les Hughes to WN283.[164]

8.155 WN283 acknowledged in her 1989 statement to the Police and her subsequent statement to the Inquiry[165] that she had received disclosures of abuse from WN282 and WN283, among others. She did not report the matters to the Police nor Children's Services.

8.156 WN23 describes another girl at the home suffering sexual abuse at the hands of Les Hughes, and she encouraged her to phone Childline, which was being publicised at that time by Esther Rantzen. She described accompanying the girl to the phone box, but she was unable to recall whether any action resulted from that.[166]

8.157 In 1988, WN816 disclosed to the Duty CCO, Hal Coomer, that she had been sexually assaulted by Les Hughes at the Home. As was recorded contemporaneously, this was passed to Marnie Baudains who interviewed WN816 and WN23. During this interview, WN23 said that nothing similar had happened to her.[167]

8.158 In 1989, WN23 disclosed to her CCO, Marnie Baudains, that she had been sexually abused by Les Hughes. In her oral evidence to the Inquiry, WN23 said that she felt that Marnie Baudains was very understanding and supportive. WN23 said that Marnie Baudains impressed on her that she was making a very serious allegation, with huge implications, but felt that Marnie Baudains believed her.[168] By this time, WN23 had already disclosed the abuse to her boyfriend, who had believed her. WN23 goes on to describe being interviewed the following day by Marnie Baudains and Brenda Chappell, with Brenda Chappell telling her that she was duty bound to report the matter to the Police. WN23 says that she confirmed to Brenda Chappell that she wanted something done about Les Hughes, and a phone call was made to the Police, with WN23 giving her first Police statement later that evening.[169]

[163] WS000091/3
[164] WS000091/3
[165] WD009395/37; WS000725/12
[166] Day 20/59
[167] WD000191/14
[168] Day 20/71
[169] Day 20/73

WN23 describes having mixed feelings about making the disclosure to Marnie Baudains and Janet Chappell, insofar as they were supportive, but she felt that they questioned whether she wanted to go ahead with the complaint.[170] She told the Panel that she felt closer to Marnie Baudains in the run-up to the disclosure because Marnie Baudains had increased her visits due to WN23 self-harming.[171]

Blanche Pierre

8.159 Darren Picot said that he never even considered reporting the abuse at the time he was living at the Home, because of "*pure fear".*[172] He also explained that he felt that his teachers must have known about the abuse at Blanche Pierre, and went on to say the following: *" … it is not worth anyone's while losing their job over making complaints because people made complaints and they were just shoved in a drawer".*[173] He went on to say that he never told anyone of the abuse at school, for fear of being shunned. He said: *"It was bad enough being called 'foster boy' without being called 'foster boy that gets beaten', stuff like that".*[174]

8.160 Another witness, WN76, told the Inquiry that she did not disclose the alleged abuse at the time because she did not realise what had gone on the Home was wrong and regarded it as the norm. She explained that it was only through her work with children and her child protection training that she came to realise that what had gone on was "*totally wrong".*[175]

8.161 WN154 said this about why he did not feel able to disclose the alleged abuse: *"I always remember, because of being scared of Alan and Jane, there was no-one to go to if you had a problem, and just wanted to talk it over with someone, which young people do. Even when Richard Davenport, the CCO, came down, if he asked if everything was okay, I'd say 'Yes' because I was too scared to say anything else."*[176]

[170] Day 20/73
[171] Day 20/76
[172] Day 25/118
[173] Day 25/130
[174] Day 25/131
[175] Day 29/69
[176] WS000114/3

8.162 In a 2008 statement, David Dallain (CCO) said that WN83 had disclosed at one point that Jane Maguire had hit him. He said that he approached Jane Maguire about it and she completely denied any incident had taken place, which surprised him. He said: "*I did not consider reporting the incident to my manager … as there was no corroboration. I assessed the situation and decided to take no further action and wait to see if any further allegations were made. I did this as I hoped that if there was any truth to the allegation, bringing it to Mrs Maguire and speaking to her about it would serve as a warning and stop any further incidents.*"[177]

8.163 As discussed in detail below, disclosures were finally made in 1990 by Susan Doyle and Karen O'Hara, two staff members at the Home. They reported their concerns to Dorothy Inglis, who was providing tutorials for them at the time. Dorothy Inglis reported it to Anton Skinner and an investigation commenced.

Children in foster care

1950s

8.164 Winifred Lockhart says that she reported physical abuse from her foster mother to a visitor from the "Social Welfare Department" – she said that she was quite a forceful child and felt able to speak up.[178] There are some contemporaneous records of these reports from 1953.[179]

8.165 WN964 and WN963 said that they told various people, including the Parish Constable, the school, and neighbours, about physical abuse perpetrated by their foster parents, WN965 and WN962. WN964 said that nobody ever did anything about it.[180]

8.166 WN174's physical abuse at the hands of his foster mother, WN483, was reported to the authorities by someone else, leading to the child being moved to HDLG.[181] Details of the alleged abuse were recorded contemporaneously by Children's Services.[182]

[177] WD006875
[178] Day 11/25–26
[179] WD000010/5
[180] WD006594; WD006595
[181] WD000684
[182] Day 35/34–36

1960s

8.167 Michael Laing said that he did not report alleged abuse by his foster parents at the time, because he tried to block it out. He says that he never considered approaching the Police and felt that there was a stigma attached to speaking out.[183]

8.168 WN341 said that he disclosed abuse by his foster parents to various people, including Patricia Thornton, his CCO, the Head of Children's Services, and Jim Thomson. He says that the Head of Children's Services did not want to know, but when he told Mrs Bygraves (also a CCO), she was lovely and "*said she was going to help me".* He was eventually stopped from staying with his foster parents.[184]

8.169 WN240 says that she ran away from her foster home in the early 1960s due to being forced to work for her foster mother and her foster father making lewd comments. She said that she told her social worker straight away, who immediately said that she couldn't go back. That day, they found WN240 somewhere else to go.[185]

1970s

8.170 WN31 says that she did not have the opportunity to disclose her mistreatment at the hands of her foster parents, because her foster mother was always present when anyone from Children's Services visited. She said it felt like the social workers were there to be friendly with the foster mother and "*It did not really feel like they were coming for me".*[186]

8.171 WN3 alleges that she was sexually abused by another resident in the foster home. She remembered being visited by her CCO, Marnie Baudains, about once a year and was never alone with her on these occasions. She says that she ran away at one point and saw Marnie Baudains, but she did not feel able to disclose the abuse – she generally found it difficult to speak to adults.[187]

[183] WS000003/16–19
[184] WS000242/6
[185] Day 39/76–78
[186] Day 13/32
[187] WS000470/0–11

8.172 In the late 1970s, a young child died in private foster care after having been shaken by his foster mother, Mrs Le Moignan. A few months before, neighbours had made complaints to Children's Services about the treatment of the child and his sibling.[188]

1980s

8.173 WN99 said that he was beaten by his foster father and ran away to his mother, who called the CCO, Richard Davenport. WN99 said that he was then sent straight back to the foster home, without the complaints having been taken seriously. More generally, he thought that children were unable to speak out about abuse because they thought that they would not be believed.[189]

8.174 WN803 and WN901 described making a video statement about allegations of abuse against their adoptive father (who had previously been their foster father). She appears to have been taken there by her foster mother.[190]

1990s

8.175 One child who was in foster care in the early 1990s alleges that she was regularly sexually abused by her foster father. She says that she did not tell anyone about the abuse at the time because she thought it was her fault and she must have done something wrong, and the abuse was her foster father's "payback".[191]

8.176 In 1991, a 13-year-old girl was removed from foster care at the request of the foster mother. A note from the CCO recorded that "*these foster parents have been wiped off the slate".*[192] In the following days, it appeared that something was disturbing the child and she eventually disclosed allegations of indecent assault against her foster father (WN857) to Marnie Baudains, which led to a Police investigation and disclosures of digital penetration on five occasions.[193]

[188] WD006509
[189] Day 45/67–71
[190] WS000689/2
[191] WD000301
[192] WD008598
[193] WD006607

8.177 In 1994, the mother of a child in foster care reported to Children's Services that her two-year-old child had suffered physical abuse at the hands of her foster parents, WN858 and WN859. This prompted an investigation by Children's Services and a subsequent Police investigation.[194]

8.178 Later that year, a 19-month-old girl was admitted to hospital by her foster mother, WN861. Dr Clifford Spratt, the local paediatrician, found two large bruises which he deemed non-accidental. As a result, he notified the SOJP and Children's Services, and investigations commenced.[195]

8.179 In 1998, a 16-year-old girl in foster care reported to the SOJP that she had been physically assaulted by her foster father, leading to a Police investigation.[196]

8.180 In the 1990s and 2000s, there were several disclosures of abuse in relation to WN862's alleged abuse of WN974, who had previously been in foster care. These included: a report was made by the maternal grandfather in 1995 to Children's Services; a disclosure by WN974 to the family support worker in 1997; and a disclosure to the SOJP in 1998.[197] Although there were further allegations in the following years, WN974 was unwilling to make a formal complaint.

2000s

8.181 In 2002, two or three children in foster care disclosed to their mother that they had been sexually abused by the 18-year-old son (WN884) of their foster parents, WN812 and WN813. The mother notified the out of hours duty officer the same day, who passed it on to David Castledine (the CCO for the children). He quickly informed the SOJP, who carried out an extensive investigation.[198]

8.182 In September 2003, a 15-year-old child in private foster care disclosed to her CCO that she had been indecently assaulted by her foster father. She was

[194] WD005965
[195] WD006618; WD006617
[196] WD006626
[197] WD006626
[198] WD008746

concerned about the consequences of making a formal complaint and was worried about her foster mother.[199]

8.183 In August 2006, a 14-year-old child in foster care raised allegations that she had been indecently assaulted by her foster mother's fiancé. She initially told her foster mother, who reported the matter to the SOJP.[200]

Summary of evidence set out above in relation to individual homes

8.184 Throughout the period under review, ad hoc disclosures were made to staff in children's homes – either by the child themselves, or by a relative, by another member of staff, or by a friend. Therefore, we look below at the individual homes and services to examine the reporting of abuse in each of them.

Jersey Home for Boys

8.185 Children made disclosures to staff at the Home, to the SOJP, and to the Constable. Other children were unable to make disclosures, either because they were scared, they had been threatened with punishment, they did not think they would be believed, or they did not realise that the sexual abuse was not normal.

Jersey Home for Girls

8.186 Children generally did not disclose because there was nobody to complain to, or because they were scared. When children did disclose to staff, staff responded that they could not intervene, that there was nothing they could do and that the children should not tell anyone. One child allegedly told a teacher about being abused; the teacher did believe her, but there was no follow-up from this.

Sacré Coeur

8.187 Some children say they complained to Children's Services, others said that there was nobody to speak to and that they would not have been believed had they done so. Complaints were also said to have been made to the nuns and

[199] WD006628
[200] WD006624

to the Mother Superior of the Orphanage, leading to the children being punished.

Haut de la Garenne (1960–1969)

8.188 Many witnesses said that that they did not report their abuse because they did not think that they would be believed. One, who alleged abuse by senior members of staff, said that there was nobody they could tell. Some said that they reported allegations of abuse to the Police or to visiting doctors. Others said that they disclosed to members of staff, including to the Superintendent, Colin Tilbrook. On some of these occasions, the children were disbelieved; on others, they were punished for their disclosures, or abused further. Members of staff said that if they had had any concerns or had received any disclosures, they would have reported them to the Police, or to Colin Tilbrook. There are at least two examples of a member of staff reporting an allegation to the Police following a child's disclosure. The case of Peter Brooks is discussed above.

Haut de la Garenne (1970–1986)

8.189 Again, many witnesses who did report allegations of abuse said that they were not believed, or that they were punished. This discouraged them from making any subsequent disclosure because they thought that there was no point. Some children disclosed allegations to relatives, who then passed on the allegations to senior members of staff. The evidence suggests that, at least on some occasions, these allegations would be passed on to Children's Services, either to inform them or with the intention that Children's Services would follow up and investigate. Allegations of abuse made against a non-staff member, Terrence Jarrett, were reported to the Police by members of staff, while allegations of sexual abuse by residents against fellow residents appear to have been addressed by staff and Children's Services without informing the SOJP. Members of staff said that there were no procedures in place for reporting abuse, but that if they did have any concerns, they would have told a senior member of staff. There are some examples of members of staff reporting concerns about the Jordans to the Superintendent.

Heathfield

8.190 Serious allegations of sexual abuse were disclosed in the late 1980s and early 1990s, either to members of staff or directly to the Police. In the 2000s, allegations were made against members of staff and people outside the Home: these were reported to members of staff, CCOs and others within Children's Services, either by the child themselves or by their friends or relatives. Some allegations of physical abuse against members of staff were reported by other members of staff. Many of these were then passed on to the SOJP for investigation, although there were some low level allegations that were dealt with only by Children's Services. By 2005 there appears to have been procedures in place for responding to allegations of abuse, but it is not clear at what stage, if ever, there were any effective systems in place for the reporting of abuse.

La Preference (Private/Voluntary Home)

8.191 A small number of disclosures by residents were made in relation to abuse perpetrated outside of the Home by adults not employed at the Home. Some were acted upon and some, according to former residents, were not. One witness did not disclose because she thought she would not be believed.

La Preference (States run)

8.192 Several reports were made by children or their relatives alleging physical assault by staff members during the 1990s and 2000s – these were generally made to CCOs or other members of staff. A small number of disclosures were also made in relation to abuse taking place outside of the Home.

Brig-y-Don (States run)

8.193 There are two instances of complaints being made – one by a resident and one by a court-appointed psychologist.

Les Chênes

8.194 In the 1980s, residents said they were threatened not to make complaints and would not have known how to do so anyway. Some former residents said that

they did not complain because it would not have got them anywhere, or that there was nobody to whom they could complain. There was nobody for them to speak to, and when they did complain, they were punished. One said that they disclosed a physical assault to a Magistrate, but were told that they must have deserved it. In the 2000s, some children did make complaints about physical abuse – either to CCOs or to the SOJP – leading to investigations. At least one disclosure was made to members of staff about sexual abuse outside of Les Chênes, which was then immediately reported by staff to the SOJP. In this period, it does not appear that disclosures were made pursuant to any particular system in place, but it does seem that residents were at least aware that they could make complaints, whether to their CCO or directly to the SOJP.

Family Group Home run by WN279 and WN281

8.195 There are contemporaneous records of complaints of physical abuse being made in the 1970s to school teachers, and then subsequently to a CCO, Ms Hogan. On the first occasion on which Ms Hogan investigated the allegations, teachers said that the children at the Home often talked of being hit on the head. On another occasion, one of the children disclosed to a member of staff that he had been hit by WN279, which she then reported to Brenda Chappell. In relation to both incidents, there does not appear to have been any system in place under which staff were required to report the allegations to the SOJP.

Clos des Sables

8.196 In the 1960s, one child disclosed to the Houseparents that he had been sexually abused in the UK before arriving at the Home: this was reported to Children's Services, albeit accompanied with the Houseparents' view that the allegations had been invented. During the lengthy period in which Les Hughes was committing sexual assaults against girls in the Home, some of the girls made complaints to a staff member, WN283. However, as discussed in Chapter 9, these were not acted upon. In 1988, some disclosures were made to a Duty CCO and, in 1989, significant disclosures were made by one of the girls to Marnie Baudains, her CCO. This happened after a long period in which a relationship of trust was built between WN23 and Marnie Baudains.

Following receipt of the disclosures, the matter was reported to the SOJP. Although disclosures were made and were acted upon at this time, this does not appear to us to have been facilitated by any system, but as a consequence of the relationship between a CCO and a child in care.

Blanche Pierre

8.197 Some children said that they did not make disclosures at the time because of fear; another did not realise that what was happening to them was wrong. One disclosure of physical assault was made to a CCO, but this was not passed on to his Manager because he assessed the situation and thought that because there was no corroboration, the disclosure would go nowhere. Disclosures were made in 1990 by two staff members, Sue Doyle and Karen O'Hara: these related to what they had witnessed, rather than to disclosures made by children placed there. They told Dorothy Inglis, who passed the matter on to Anton Skinner, Children's Officer. Although these disclosures were investigated to some extent at the time, there was no multi-agency approach and no system existed to facilitate these disclosures, despite the multi-agency CPT being in existence, albeit in embryonic form. The Police were not informed at the time.

Children in foster care

8.198 Disclosures were made throughout the relevant period, either by the child themselves or by others who had concerns about the abuse, including relatives of the child. The disclosures were largely made to CCOs or someone else within Children's Services, although in the later period in particular, complaints were also raised directly with the SOJP. Some children say that they had nobody with whom they could raise complaints, because even when their CCO visited, they did not have the opportunity to see them on their own.

Findings: Reporting of abuse

8.199 Below, we set out generic findings on the reporting of abuse, having summarised the evidence on the reporting of abuse at each Home.

8.200 We have considered a large amount of witness evidence about the reporting of abuse and about the reasons given for not reporting abuse. Although some of the accounts arise from oral evidence to the Inquiry, many were taken from witness statements; these were not tested in oral evidence. Some of the accounts are corroborated by contemporaneous records and/or other witness evidence, others are not. As a result, we have not made findings in individual cases as to whether or not disclosure took place.

8.201 Concerns about abuse were raised in a multitude of different ways, across the whole of the relevant period. They were raised by the children who had been abused themselves; their friends, relatives, and teachers; by CCOs; and by residential child care staff.

8.202 Where concerns were raised, they were reported to a variety of people. The most common route of disclosure was to the child's CCO or to someone else in Children's Services. However, disclosures were also made to parents, teachers, friends, residential child care staff, the Police, and others.

8.203 There is no evidence before the Inquiry that any child in residential or foster care who raised allegations of abuse did so by reference to any formal policy in place. For a large proportion of the period with which the Inquiry is concerned, there were no formal Polices or procedures in place, and no systems relating to the handling of disclosure that we can identify. The formation of Childline in 1986 did not amount to a system for reporting concerns, but did provide an outlet for some. We recognise that at least until the late 1980s this was in line with the approach taken generally in the UK, but note that policies and procedures in Jersey were behind those in the UK. Children in care therefore had to use their own initiative if they wanted to make a disclosure. A child decided to whom, and in what circumstances, he or she could safely make an allegation of abuse.

8.204 From the late 1980s and early 1990s, policies and procedures began to be introduced relating to the processing and handling of disclosure. The recording and processing of disclosure appears to have increased at this time in line with the development of multi-agency working. However, these systems still had significant flaws – they do not appear to have been effectively brought

to the attention of children and consequently were of little, if any, practical benefit either to children in residential care, to residential care staff or to CCOs.

8.205 By 2005 it is clear that a formal system was in place – however, there is a significant question about how widely these procedures were made known and whether they were used by staff or children. Further, these procedures largely replicated English guidance from 1991, providing another example of Jersey lagging significantly behind policy and practice elsewhere.

8.206 In his 2008 statement, WN688, an employee of Children's Services, said that *"Until about five years ago, there was not a complaints procedure, before that it was a cloudy picture as to what and how complaints were recorded and investigated. There [were] no set guidelines and who to report to and who investigated the matters. I have reported things in the past and was told that unless I had evidence or proof to substantiate what I was saying that there was nothing that could be investigated."*[201] This suggests that even if there were systems and procedures in place by the early 2000s, they were not sufficiently well known by Children's Services staff to be useful in practice. This we find was an inadequate approach.

8.207 The absence of an identifiable reporting system for much of the relevant period made it very difficult for children, staff and the general public to make complaints or raise concerns. Children in the care system were often powerless. While we recognise that up to the late 1980s this was the approach generally, we record our dismay that children's accounts went unheard and discounted. There were no systems in place – whether they were adequate or not over this period does not fall to be assessed.

8.208 The reasons why children in care did not feel able to report abuse are varied. Many felt they would not be believed and said that the prevailing culture at the time was that children did not speak up. Some accepted their abuse as a normal part of life. Some were unable as children to articulate their experiences and were only able to speak out years later.

[201] WD003532

8.209 Although the responses to allegations of abuse are addressed in Chapter 9, we note that one of the reasons why children did not disclose is that they had previously disclosed and had either been disbelieved or had been punished. It is clear to us that the absence of a system for reporting and the culture in various institutions further reduced the likelihood of children making disclosures. We note that a number of children would still not have been able to disclose at the time, regardless of the system or culture. The barriers to disclosure that we have identified above are ones that have been found in other reports on child abuse.

8.210 Notwithstanding the lack of a formal system and the various reasons for non-disclosure, there were disclosures throughout almost the entire period. Many of those, particularly from the late 1980s onwards, were to a child's CCO. We do not think that this amounted to any system, yet alone an adequate one, but we recognise that this was an important outlet for children and that such disclosures often depended upon regular contact and the development of a relationship of trust.

8.211 From the late 1990s, an increasing number of disclosures were made directly to the SOJP. Again, we do not consider that this amounted to a system, let alone an adequate one, yet again we recognise that there must have been some information provided to children in care that they were able to make complaints directly to the Police. On the basis of the evidence, we do not know whether this information was provided by the Police themselves, or by Children's Services.

8.212 We consider that Term of Reference 8 does not require us to make findings on the reporting of historic allegations and the systems in place to facilitate such reports. We have focused on the reporting or non-reporting of contemporaneous or recent allegations. However, we think it important to record that by the 2000s, large numbers of allegations of historic abuse were being made and were being investigated, particularly as part of Operation Rectangle. Prior to this time, with a few exceptions, there were no reports of non-recent allegations of abuse by children formerly in care.

8.213 With regard to the effect of the political and societal environment, we note that at least over the early part of the relevant period, Jersey society remained patrician and hierarchical: those in care remained in our view marginalised, and their standing low. In line with societal views in the UK at the time, the views of children, and more so of children in care, were given scant regard over those of adults in whose care they were maintained as well as those in authority. That children will have been disbelieved or were fearful of coming forward is in part a reflection of how those in care were viewed by the society charged with their care.

8.214 The evidence we received points to the Jersey child care system being one in which there was abuse of children. That abuse, in many cases, was not dealt with because of the lack of any means of supporting children to make complaints or raise concerns. The voices of children were effectively ignored over many decades.

CHAPTER 9

The Response of the Departments of Education and Health and Social Services to Allegations of Abuse

9.1 Under Term of Reference 10, we are asked to consider:

- the response of the Education and Health and Social Services Departments to concerns about alleged abuse;
- what action they took;
- whether those actions were in line with the policies and procedures of the day; and
- whether those policies and procedures were adequate.

9.2 We have interpreted the "Education and Health and Social Services Departments" to include all staff working within those Departments – including residential child care staff, those in charge of the relevant Homes, child care officers (CCOs), Senior Managers within Children's Services, and the Directors of Education.

9.3 When examining the action taken by the Departments, we have focused primarily on cases in which there was at least some action taken. As set out in Chapter 8, we acknowledge that a substantial number of witnesses gave evidence that, when they reported abuse, no action was taken at all.

Policies and procedures

9.4 In order to establish what the policies and procedures of the day were, we have considered the evidence of witnesses to the Inquiry, as well as the documentary disclosure provided by the Departments. Our view is that for something to constitute a policy or procedure, it must be a written or properly communicated guide about how an individual should act in certain circumstances.

9.5 We considered whether the Education Committee's "Agreed Code of Practice" on "Child Abuse/Non-Accidental Injury"[1] from 1987 could be regarded as a relevant policy or procedure, particularly given that Anton Skinner told us in evidence that non-accidental injury procedures would have gone out to all homes, with a prescribed set of action to be taken if there was a suspicion of abuse.[2] However, we concluded that the 1987 Code of Practice did not amount to a relevant policy or procedure for the purposes of Term of Reference 10. In our view, this code of practice is clearly directed towards suspected abuse where the child is living in the family home, and would not have been relevant to concerns about abuse where a child was in residential care. For example, a child would not have been placed on an "at risk" register when they had already been admitted into care.

9.6 We note that in addition to the 1987 non-accidental injury code of practice, there are several other policies and procedures that address the response to concerns about allegations of abuse – however, those that are not listed below (including, for example, the Child Protection Guidelines from 1991[3] and 2000[4]) do not include policies and procedures that would be applicable where a child in care is making an allegation of abuse, whether against a staff member or someone outside of a children's home. We note that these procedures,[5] from 1991, refer to a Child Protection Co-ordinator who would "*oversee the effective co-ordination of these procedures",*[6] however we have seen no evidence of any involvement of such an individual in responding to allegations about children in care, and no evidence at all about the work carried out in that role until the 2000s.

9.7 Some of those who worked in Children's Services at the time made reference in evidence to policies and procedures – Anton Skinner said in evidence that these were available in the late 1980s[7] and Marilyn Carre remembered a protocol in existence before 1989 that CCOs were required to follow where it

[1] WD006302
[2] Day 88/6
[3] WD009137
[4] WD005237
[5] The 1991 Child Protection Guidelines, as well as the 2002 Sexual Misconduct Policy and the 2004 Allegations against Staff Policy listed below
[6] WD009137/5
[7] Day 88

was suspected that a child had been sexually abused.[8] Furthermore, the Child Protection Team (CPT) was established in 1989 and received considerable publicity.[9]

9.8 However, we note that the Inquiry has seen several examples of disclosures of allegations of abuse relating to children in care in the late 1980s and early 1990s. These include the allegations against WN637 in 1987, the allegations against WN766 in 1988, the allegations against Les Hughes in 1989, the allegations against the Maguires in 1990, and the allegations against WN335 in 1991. All of those allegations were investigated. In none of them was there any reference to policies and procedures that were or were not being followed.

9.9 Thus, we conclude that the Departments did not have any policies and procedures for responding to concerns about abuse of children in care until the 1990s at the earliest, and potentially well into the 2000s. This does not therefore mean that we criticise all responses to allegations of abuse until this time. It means simply that these responses cannot be assessed against the "policies and procedures of the day", because there were no such policies and procedures.

9.10 We note that in England, in 1991, the "Working Together under the Children Act 1989" guidance[10] included a section on abuse of children in residential settings – by other children, visitors and members of staff.[11] It set out that "*policies and managerial procedures must openly recognise the possibility of abuse and must prevent creating circumstances which could encourage abuse. There must be clear written procedures on how suspected abuse is dealt with, for children and staff to consult and available for external scrutiny".* The guidance says that abuse by visitors should usually be dealt with in the same way as stranger abuse, and needs to be recognised in the vetting and recording practices.

[8] Day 81/11
[9] GD000018/16
[10] This was updated in 1999
[11] EE000147/42–44

9.11 With regard to abuse by staff, the guidance says that it is "essential" that children and staff are encouraged to report their concerns to the appropriate persons in the local area, and that the procedure for this should be in written guidance and reinforced through training and supervision. Those in authority should be encouraged to treat concerns speedily and appropriately, and ensure correct and effective action. Procedures should make clear the action that should be taken if the member of staff is dissatisfied with the initial response.

9.12 The guidance goes on to say that where abuse by a member of staff is suspected, the action to be taken is the same as with any other suspected abuse – the local investigating agency should be informed immediately and other agencies involved as appropriate. Investigations of alleged abuse by a member of staff within the Social Services Department should include an independent element where possible (for example, from another Department, or the local NSPCC). Where possible, the investigation should be carried out by a senior member of the Department without line management responsibilities for the Home in which the alleged incident occurred. Those who are investigating need to recognise that abuse by staff in a residential setting can pervade the whole environment, possibly with the collusion of other members of staff, therefore they will need to pay regard to the possible need for secrecy.

9.13 Finally, the guidance goes on to note that three separate strands of investigation may need to be followed – (i) A child protection investigation; (ii) A police investigation, and/or (iii) An employer's disciplinary procedures. It is stressed that it is "*of the greatest importance that those in authority are clear that, although there may be insufficient evidence to support a police prosecution, this does not mean that action does not need to be taken to protect the child, or that disciplinary procedures should not be invoked and pursued".*

9.14 We consider that the "Working Together" Guidance of 1991 reflects the standards of the day.

9.15 Table 9.1 sets out what we consider to have been the relevant policies and procedures in Jersey at the relevant time.

Table 9.1: Child Protection Policies and Procedures

Doc Reference	Date	Policy/Procedure
WD000604	Nov 1991[12]	Education Committee: Residential Child Care Staff – Disciplinary Procedure. Sets out that, in cases of gross misconduct or urgency, on receipt of a report of the matter, the Children's Officer (CO) may immediately suspend the employee and follow the disciplinary procedure.
WD008545	Jul 1994	Children's Rights and Complaints Procedure. Sets out complaints should initially be handled at a local level. It also sets out that a serious complaint that cannot be dealt with at local level can be made to the CO, who will register the complaint and appoint an Investigating Officer to conduct an enquiry. A written record will be kept of the whole process, and disciplinary procedures may be invoked at any stage. A final report will be made by the Investigating Officer to the CO. We did not receive any reference to the invocation of this procedure in evidence to the Inquiry.
WD009349	Aug 2002	Sexual Misconduct Policy for Children's Services. Sets out that employees of the Children's Service have a duty to follow the Child Protection Policy of the unit and the Health and Social Services Committee, to report a suspicion of sexual or physical abuse to the Child Protection Co-ordinator. If reasonable grounds to suspect abuse, the matter must be referred to the CPT without beginning an internal investigation that could compromise the CPT investigation. It is not clear what the references to the Child Protection Policy of "*the unit"* mean. We did not receive evidence of children's homes having individual child protection policies at this stage.

[12] A similar copy of the same document was also received which is from March 1990

WD009035	Jul 2004	Child Protection Committee Guidance: Allegations against Staff. Sets out procedure whereby a member of staff receiving a complaint of abuse against another member of staff must immediately inform their line manager or the designated person for child protection. That person must then immediately liaise with the Child Protection Co-ordinator Professional for the Organisation. If the criteria are met, a strategy discussion will be held. It is stated that it is not up to the recipient of the allegation to determine the validity of an allegation and failure to report could result in disciplinary action. Notes that sexual misconduct can occur even if a young person has reached the age of consent. Although this guidance seems to be focused on educational staff and doesn't specifically mention staff in care homes, we think that it likely has broader reach.
WD008591	Aug 2005	Children's Services Child Protection Procedures. Sets out that it is important to note that child protection procedures apply equally to children living away from home as for all other children. Allegations of abuse against staff, foster carers or volunteers should be referred to a Senior Practitioner or Team Manager in the Assessment and CPT. If a criminal offence may have been committed, a strategy meeting should be convened with the police. Investigation can include child protection enquiries, a police investigation, and/or disciplinary proceedings. The fact that a prosecution doesn't follow does not mean that action in relation to safeguarding children or employee discipline is not necessary. The investigation should be completed thoroughly and as quickly as possible. If allegations are substantiated, managers should think widely about the lessons of the case and how these can be acted upon. Historical allegations should be treated in the same way as contemporaneous allegations.
WD009052	Aug 2006	Civil Service Disciplinary Policy. This was applied to staff

		accused of abuse. Sets out that gross misconduct, including assault or sexual offences, will normally lead to summary dismissal.
WD009213	Sep 2010	Memorandum of Understanding for investigations into serious incidents. Includes criminal conduct alleged against an employee of the States of Jersey which might cause significant damage to the reputation of the States of Jersey. Unclear if applied to residential care staff. Notes that States Employment Board has a duty to discipline, suspend or terminate the employment of States' employees.
WD009244	Feb 2011	Jersey Child Protection Committee Multi-Agency Child Protection Procedures. Sets out various principles than underpin the management of allegations against any person who works with children, and goes on to set out procedures to be followed. Sets out that no resignation is to be accepted during investigation.

9.16 We note that the Child Protection Procedures in 2005 are similar in content to that which existed in the English "Working Together" guidance from 1991 (set out above). This is perhaps unsurprising, given that the 1991 English guidance went alongside the *Children Act 1989*, and it was not until the *Children (Jersey) Law 2002* (implemented in 2005) that similar legislation was passed in Jersey.

9.17 When shown the 1991 UK "Working Together" document, which included guidance on responding to disclosures, Sean McCloskey stated that no similar procedure was in place at Heathfield at the time of allegations about WN335 in 1991, nor by the time he left in 1999.[13]

9.18 In evidence to the Inquiry, Phil Dennett said that there was a very clear process (in the context of a question about the mid-2000s) in that the police investigation takes priority and goes first, and once this has been completed,

[13] Day 69/170

then they would look at a disciplinary process. Invocation of the disciplinary process was discretionary and would be done following discussions with the SOJP and colleagues, taking into account the context of the incident and the seniority and experience of the member of staff. He said that regardless of whether a disciplinary process was instigated, there would be a risk assessment about the suspected member of staff.[14]

9.19 We have not considered whether the policies and procedures were adequate in isolation, but have considered whether the practice was adequate.

Responses to allegations

9.20 Consideration of this topic can be illustrated by reference to individual homes and to the fostering service. We have made findings in relation to individual cases where we considered it appropriate.

9.21 This chapter also includes the responses of witnesses to allegations of abuse that were made against them, or others. In doing so, we fulfil our requirement under Term of Reference 7 to hear from staff who worked in the relevant services, as well as ensuring, in the interests of fairness, that individuals are given the opportunity to comment on allegations made against them and others. The allegations of abuse made by former residents, as well as their perspective on members of staff and others, are set out in Appendix 2, as discussed in Chapter 7.

Haut de la Garenne (1959–1969)

General evidence of care staff about allegations of abuse

9.22 Audrey Mills told the Inquiry that she "*never saw anybody hit or abuse a child during my time at Haut de la Garenne*" nor did she see or hear of anyone being "*abused or thumped in the detention rooms*".[15] During her five years working at the Home "*no alarm bells were rung for me*".

[14] Day 134/19–21
[15] WS000585

9.23 Margaret Davies told the States of Jersey Police (SOJP) that throughout her time at the Home she was never aware of any physical or sexual abuse. She was never approached by children or staff about abuse.

9.24 WN8 (1962–1964) recalled that children were "*roughly handled*". She described seeing a child tied to a table.[16] She said that boys did disclose to her that a male member of staff was doing things to them: "*I did not realise what they meant at the time.*"[17]

9.25 WN512 said that she did not see staff in the dormitories during the night shift and that no-one reported to her any incidents of sexual or physical abuse. There were no members of staff or children that she was concerned about in relation to sexual abuse. If she had had any concerns, she said, she would have gone to Colin Tilbrook.[18]

9.26 An individual employed in the nursery and at nights in the 1960s said that she had not been aware of any form of abuse taking place when she worked at Haut de la Garenne (HDLG) nor was she aware of any rumours. Had she been she would have reported these to the police.[19]

9.27 WN615 (1966–1970) remembered one member of staff who "*seemed to be searching children regularly but not finding anything*", the implication being that he was touching children. WN615 and Ray Williams reported their concerns to Colin Tilbrook after which, "at some stage", the member of staff concerned left HDLG.[20]

9.28 WN602 (1965–1966) remembered being told off for slapping a boy across the face: "*I got into trouble for that. There were certain rules to be observed*." The Inquiry has not seen any records in relation to this incident. WN602 said that although HDLG was very strict she did not recall seeing any violence or boys complaining to her about being hit.[21]

[16] WD006741
[17] WD006741
[18] WD001881/9
[19] WD006639
[20] WD001881/9
[21] WD006913

Peter Brooks

9.29 Although this case is also discussed in Chapter 8, in the context of the reporting of abuse, it is particularly relevant in this chapter because of the response to the allegation of abuse.

- Children's Sub-Committee (CS-C) minutes in December 1960[22] noted the view of the Superintendent that Peter Brooks was not "effective" with the senior boys' group and that his position was to be advertised. He had been recruited from the UK.
- On 17 January 1961, the boy disclosed to the Deputy Superintendent that Peter Brooks went to the boy's bed at night and touched him under his nightclothes; he had also been sexually assaulted in Peter Brooks' bed.[23]
- On 18 January 1961, the day after the disclosure of sexual abuse, the CS-C convened a "special meeting" at 6:30pm. The meeting was attended by Patricia Thornton, the Deputy Superintendent and by three co-opted members of the Executive Committee. The minutes are set out in full below:

> *"Mrs Thornton reported to the subcommittee that the evening previously Mr Mallinson had asked her to go to Haut de la Garenne in order to tell her that a 14-year-old boy had run away earlier in the evening. He had been found by Ms Mallinson [and another member of staff]. He was very upset and stated he was going to see Miss Thornton to tell her of certain indecent behaviour of Mr Brooks. Ms Mallinson managed to take him back to Haut de la Garenne. He had then described in detail to Mr and Mrs Mallinson things which had occurred.*
>
> *The subcommittee then talked to Mr Mallinson and, after discussion, decided that they must have a statement from the boy himself. The boy came in and, without any prompting, told the Committee very much the same story he had told Mr Mallinson. After the boy had left the room and the subcommittee had had a further discussion, deputy Mrs Green rang the President of the Education Committee and Senator John Le Marquand joined the meeting. It was then decided to interview Mr Brooks, the Assistant Housefather.*
>
> *Mr Brooks looked extremely distressed. When asked if he knew the reason for the interview he stated yes, he had hit the boy in question. When pressed further, however, he admitted to having had the boy in*

[22] WD006522
[23] WD006667

> *his room and he later admitted that the boy had been in his bed. His statement coincided in many ways with the statement made by the boy. When Mr Brooks left the room the President rang Brigadier MacPherson who joined the meeting, and also Dr Wishart for his advice.*
>
> *After lengthy discussion the Committee decided that it was their duty to inform the Attorney General. The President then rang the Attorney General and, a short while later, Centenier de la Mare came to Haut de la Garenne. After speaking to the committee he went into another room and interviewed Mr Brooks who admitted the affair. The Centenier then took Mr Brooks into custody."*[24]

An Executive Committee minute dated February 1961 recorded:

> *"the Committee was informed that Mr PL Brooks who had been appointed Assistant Housefather at Haut de la Garenne Children's Home as from 1 December 1960, had admitted allegations made against him by one of the boys at the Home and that the matter had been referred to the Attorney General."*[25]

- The minutes contain no further reference to the incident. There is no record available to the Inquiry as to whether steps were taken to review procedures in the Home. It is not known whether a report was sought from Patricia Thornton (CO) or from Mr Mallinson (Acting Superintendent).
- A newspaper report of the case refers to the CO, Patricia Thornton, having made "*routine checks and had found nothing against him*".[26] When Peter Brooks had been recruited from the UK, he had some experience in schools and four references had been obtained, which were all positive. [27]
- Peter Brooks was dismissed in January 1961 and convicted in February 1961 of two cases of indecent assault on a 14-year-old boy at HDLG.
- Following conviction, Peter Brooks was bound over for three years and had to leave Jersey. He was also required to undergo a course of medical treatment.[28] There is reference to arrangements for the boy to see a psychiatrist, although given the context in which this is set out in the

[24] See Appendix 5 to Closing Submissions of Counsel to the Inquiry
[25] WD001167/3
[26] WD001167/2
[27] WD006668
[28] WD006667

psychiatrist's letter to the Attorney General (AG), the concern may have been directed towards fears that the boy was homosexual.[29]

9.30 **Finding:** In our view, the response to this disclosure of abuse was more than adequate according to the standards of the time. While there were no systems in place, the child's account was taken seriously and acted upon. The member of staff, Peter Brooks, was asked by senior management to respond to the allegations. The matter was then promptly reported to the AG and the Education Committee, and subsequently to the police, and action was taken to dismiss Peter Brooks. Additionally, there appears to have been at least some consideration given to the child's welfare.

Ray Williams

9.31 Ray Williams joined the staff at HDLG in 1966 as a Housefather for the intermediate group. He had no previous professional experience or training, having been a swimming pool attendant.

9.32 As set out in Chapter 8, in 1976, a female resident (WN346) complained about Ray Williams watching her while she dressed. She wrote a seven-page account in a notebook detailing what Ray Williams had done, her concerns, and the action that she and friends decided to take. The tone of the letter suggests genuine distress on the part of WN346.[30]

9.33 The complaint was further set out in a typed memo from WN491 (a member of staff) to Colin Tilbrook. The memo, dated 1 May 1967, faithfully relayed WN346's complaint and described it as a "*rumour*". The memo named other residents supporting the complaint and concluded: "*So far I have stopped them from going out this weekend for spreading malicious gossip.*"[31]

9.34 On 30 May 1967, Colin Tilbrook wrote a memo to the CO, marked "confidential", which said that he had:

> *"a long, frank talk with Mr Williams … I discussed the recent allegations made against him as well as the problems he has had in making*

[29] WD006666
[30] WD006839/7
[31] WD006639/8

> *satisfactory relationships with certain members of staff ... I also told him that he should so arrange things that there is no opportunity for any criticism from anybody inside or outside to complain. He well understood the nature of our conversation and has learnt from me, in no uncertain manner, that if there are frequent complaints in the future we should have to consider his position very carefully. I will keep a very close watch".*[32]

9.35 The timing of Colin Tilbrook's memo and the reference to "*recent allegations*" suggest that the Superintendent was addressing WN346's disclosure among other issues and that "*the recent allegations*" were already known to the CO.

9.36 In November 1968, WN491, a member of staff, wrote a confidential memo setting out an account of mounting friction between Ray Williams and staff member WN515. In that memo he *"warned"* Ray Williams about "*his future conduct*".[33] The existence of the memo reflects the fact that, in the absence of Colin Tilbrook, WN491 could discipline staff.

9.37 A memo in January 1969 by Colin Tilbrook notes:

> *"Mr Williams – 14.1.1969 – very truculent, ill-tempered and rude to me in office complaining that I had been criticising the care that he and [WN615] take of their group. (Three children in morning were sent to me by [WN615] because they did not have all their school outfits). Had scene with [staff?] and was in near uncontrollable rage.*
>
> *15.1.69 had argument with [WN187] and had [WN187] round neck in strangling action."*[34]

9.38 In her statement to the Inquiry, Margaret Davies said that she was not aware at the time that Ray Williams acted inappropriately towards children.[35] She was shown Colin Tilbrook's reference and stated that she did not remember the criticisms being an issue at the time.

9.39 WN615 had no knowledge of Ray Williams being physically violent to children and never witnessed any sexual abuse by him.[36]

[32] WD006636
[33] WD006638
[34] WD005821
[35] WS000606
[36] WD00188/6

9.40 Colin Tilbrook dismissed a complaint of bullying by Ray Williams made by WN126. He claimed that Ray Williams was picking on his brother, WN195, and had pushed him into the pool.[37]

9.41 He left in 1970 and returned to the UK, applying for posts in residential child care. A local authority's CO asked Colin Tilbrook for his opinion as to Ray Williams "*suitability for this type of work*". Colin Tilbrook replied[38] that Ray Williams needed "*support, guidance, encouragement and supervision*" and had "*considerable difficulty sometimes with more disturbed youngsters … admits to be a rather belligerent man as well as quick-tempered*" and at times had "*considerable difficulty in [his] relationship with other members of staff*". The reference concluded that Ray Williams had "*difficulty in accepting normal professional disciplines*" and was inclined to be very "*prickly and huffy*", but had a "*deep concern for children in difficulty".* Ray Williams had been in charge of adolescents at HDLG for four years by this stage.

9.42 A number of allegations of physical and sexual abuse were made against Ray Williams during Operation Rectangle, by which point he was deceased.

9.43 **Findings:** The evidence suggests that Ray Williams was unsuited to work with vulnerable children and was not equipped to provide emotional support to children in his care.

9.44 On the basis of the contemporaneous evidence, we conclude that allegations of sexual abuse were raised about Ray Williams at the time. There was some response, in which Ray Williams appears to have been given an informal warning. We consider that even given the standards of the time, this was not an adequate response. Any complaint of sexual abuse should have been investigated beyond simply discussing the allegations with the alleged perpetrator.

9.45 We deprecate the fact that the child complainant was not believed, although note that such a response was common elsewhere at the time.

[37] WD000695
[38] WD001213

Thomas Hamon

9.46 Thomas Hamon joined the staff as a relief Houseparent in 1966. He had no previous experience and resigned the same year to return to his work at St John's Ambulance.

9.47 After he left, he wrote to Colin Tilbrook, volunteering to help in the evenings:

> *"I like those kids more than one would think, I promised them I would come up and see them, if you would allow it … I can be of help in the evenings, so please let me come up."*[39]

9.48 Colin Tilbrook replied:

> *"A little later on, when all our new staff have quite settled, it will be nice for you to call but at the moment I do feel you should wait."*[40]

9.49 In 1971, Colin Tilbrook wrote to Thomas Hamon, hoping that the boys at HDLG would continue to enjoy his "*friendship*".[41]

9.50 Margaret Davies remembered feeling "*uncomfortable*" about Thomas Hamon but did not raise any concerns with Colin Tilbrook because "*my concern was based around a general feeling of suspicion towards Mr Hamon rather than anything specific*".[42] As set out in Chapter 8, there was no system in place at the time that concerns held by staff about colleagues were to be raised with management.

9.51 WN930 recalled that Thomas Hamon was asked to leave HDLG but did not say why.[43]

9.52 In December 2005, Thomas Hamon pleaded guilty to 12 counts of indecent assault of boys relating to two separate periods, the first between 1964 and 1969 and the second between 1980 and 1989.[44] At least two of the children were former residents of HDLG and at least one of the offences occurred at HDLG. Thomas Hamon died in custody while awaiting sentence. As there

[39] WD001180
[40] WD001179
[41] WD003663
[42] WS000606/12
[43] WD006733
[44] WD000735

were no recorded contemporaneous complaints about Thomas Hamon, we make no findings in this chapter.

WN264

9.53 WN264 gave evidence to the Inquiry about visiting HDLG in the 1960s to take children out for the afternoon. An analysis carried out by the SOJP during Operation Rectangle confirmed the fact that WN264 visited the home regularly. The records[45] show that on most visits he took more than one child out at a time, although there were also entries recorded suggesting that he took children out on their own on some of his visits.

9.54 In 2003, serious allegations of sexual abuse were made by WN195 against WN264 in relation to his visits to the Home in the 1960s. When interviewed by the SOJP, WN264 denied WN195's allegations, stating that they were outrageous. He said that on no occasion was he alone with a child.

9.55 During the police investigation, a notepad was found in his home, with website addresses relating to child pornography and also torn magazine pages depicting young boys wearing fashion clothing. WN264 said that he noted down the website addresses because his computer was crashing. He had received them by a junk mail. He had the magazine pictures because they were just "*handsome young boys*". He also admitted having produced six or seven hard copies of pictures of naked boys aged between 12 and 17.[46]

9.56 The matter was reconsidered during the course of Operation Rectangle but WN264 was not re-interviewed.

9.57 In oral evidence to the Inquiry,[47] responding to the allegations, WN264 maintained that they were "*monstrous*". He also denied allegations that were put him in relation to two other former residents at HDLG who alleged that he attempted indecently to assault them in his car.

[45] WD000859
[46] WD007381
[47] Day 90; WS000617

9.58 As there were no recorded contemporaneous allegations of sexual abuse made against WN264, we cannot evaluate the response of the Education Department.

Colin Tilbrook

9.59 No allegations were made against Colin Tilbrook while he was alive, as far as the Inquiry is aware, and as a result we make no findings in this chapter about the Education Department's response. A number of allegations were made during Operation Rectangle. In her statement to the Inquiry, his former wife Margaret Davies stated that she saw nothing which "*suggested Colin might have been abusing children*".[48]

9.60 WN8 remembered Colin Tilbrook "*shouting a lot*" and holding parties at night in his flat. Another member of staff (1963–1965) wrote to the SOJP in 2007, describing him as a dictator and a bully. She never saw him harm anyone but suggested that he behaved inappropriately with other female staff at the Home. She was wary of his behaviour towards her.[49]

9.61 WN930 (1965–1966) remembered Colin Tilbrook appearing in the communal bathroom when girls were having bath. He said that he was saying good night but she thought this inappropriate.

9.62 WN602 (junior staff member 1965/6) recalled Colin Tilbrook *"ruled by fear … He would go for a few days without even talking to you … I never saw Tilbrook or* [WN491] *interact with children".*[50]

9.63 WN515 (Housefather 1967–1974) said Colin Tilbrook was "*rigid*" but the children came first and staff second – his expectations were high.

9.64 WN87 (1965–1966) says that he went to the Police, having been told that Colin Tilbrook had made a 14-year-old resident pregnant. He was told that the

[48] WS000606/16
[49] WD001894
[50] WD006913

Police would look into it. He does not say what the outcome of this disclosure was, and there are no contemporaneous records of such a disclosure.[51]

WN491

9.65 WN491 joined the staff as Housefather in 1962. During Operation Rectangle, WN491 was the subject of allegations of abuse from 15 complainants, all but one of whom alleged physical violence. There were no records of contemporaneous allegations being made against WN491, and therefore, as before, we make no findings in this chapter.

9.66 When interviewed by the SOJP, WN491 denied all allegations.[52] In relation to one of the several allegations of "towel flicking" he said that "*it is against my nature. The kids did it to each other*". He denied throwing ashtrays, books and slippers at children and hitting any child with a belt.

9.67 Other witnesses gave the following evidence:

- His daughter gave a statement to the Police, saying that WN491 never liked the children at HDLG. He had a short temper and hit her as a child.
- WN930 (1965–1966) saw WN91 "*at least 2 or 3 times*" hitting boys across the head or upper body with the back of his hand. According to WN930, WN491 used the detention room for boys to calm down.[53]
- WN514 described WN491 as an "*autocratic disciplinarian and the kids respected him for it*".[54]

Senator Wilfred Krichefski

9.68 As noted elsewhere, allegations have been made about sexual abuse committed by Senator Wilfred Krichefski. Although there is no evidence directly from Senator Wilfred Krichefski as he was deceased by the time allegations were made, the following background evidence has been obtained about him:

[51] WD006727
[52] WD006931
[53] WD006733
[54] WD006768

- He was on the appointment Panel for Superintendent and Matron at the Jersey Home for Boys (JHFB) in 1946.[55]
- He was a visitor to JHFB in 1947, to interview boys leaving school.[56]
- He was a guest speaker at Brig-y-Don (BYD) in November 1973.[57]
- Research was carried out by the SOJP into him in July 2008.[58]
- Information was received from a former SOJP officer, Barrie Stead. He initially alleged that he investigated Senator Krichefski in the 1960s and was told to stop. [59] He later denied making these allegations.[60]
- Evidence was received by the SOJP of a blackmail demand, making allegations against Senator Krichefski and others.[61]

Jeff Le Marquand

9.69 In July 1966, a child was admitted to HDLG when facing charges of "being destitute". While at HDLG he made allegations of sodomy against Jeff le Marquand and another man.[62] Jeff le Marquand (now deceased) was, at the time, the owner of a shop in St Helier.

9.70 WN491 (staff member) reported the allegations to the SOJP and an investigation commenced. A Children's Office memo dated 2 August 1966, a few days later, noted that the police had advised that the child allegations "*have been sufficiently supported by evidence for a charge to be preferred … two men will appear in the Police Court today and … The Police will formally ask for one weeks remand. In view of the fact that [the child] appeared to be a willing partner and as we cannot rule out the possibility that he may have a VD infection, he will be on his own but will be exercised. The M.O. will see him again on 3.8.66*".[63]

9.71 One week later, a letter from Colin Tilbrook to Patricia Thornton noted that the child complainant (age 15) was still locked up at HDLG:

[55] WD006459
[56] WD006460
[57] WD006463
[58] WD001661
[59] WD006439
[60] WD006440
[61] WD006438
[62] WD006419
[63] WD006432

> *"We have no authority to detain the boy as I understand that there is no charge against him. In view of this I have explained to the child that we have no authority to lock him up and sought his permission to do so because of the fear the doctors have of possible infection and also because we wished to ensure nobody made an attempt to harm him. My own feelings are that this boy was a very willing accomplice in the "sodomy" charge and may be a very bad influence on other children and should therefore be kept separated from them."*[64]

9.72 Documents from 1971 show that Jeff le Marquand was attempting to gain access to HDLG, having recently been released from prison. He was not allowed into the building.[65]

9.73 No further contemporaneous documents exist, but a 2008 SOJP report noted that Jeff le Marquand's accomplice was convicted (in the 1960s) and sentenced to 18 months' imprisonment.[66]

9.74 Further documents suggest that there was other intelligence provided to the SOJP about Jeff le Marquand's alleged reputation as a paedophile.[67]

9.75 **Finding:** The initial response to this disclosure of abuse was appropriate. Despite there being no systems in place at the time, WN491 reported the allegations to the SOJP and an investigation commenced. However, the response to the child complainant, even according to the standards of the day, was inadequate. He was locked in the detention room on the basis of a suspicion that he might be a bad influence on other children.

Haut de la Garenne (1970–1986)

9.76 This section sets out the responses of members of staff and others at HDLG to the allegations of abuse made against them or other staff members. A number of individuals who worked at or were connected to HDLG only became the subject of formal allegations of abuse after they had died.

[64] WD006435
[65] WD004323
[66] WD006435
[67] WD006430; WD006013/2; WD006426; Day 46/8

Evidence of care staff re general allegations of abuse

9.77 As a volunteer for four years, Ernest Mallet (1970–1974) told the Inquiry that the Home seemed "*quite a happy place … There did not seem to be any major things going on".*[68]

9.78 Marion Robson was not aware, while she was at HDLG, of any complaint of children being caned excessively.

9.79 WN287, in the short time that she was at HDLG, was not aware of any abuse and said it was "*an okay place to work*".[69] When she trained in the UK in child residential care and started work at HDLG, concern about sex abuse was simply "*not on the radar*".

9.80 Wendy Castledine (1974–1978; 1980–1985) told the police that she "*never witnessed any cruelty or inappropriate behaviour towards any children in our care … None of the children ever made any allegations of any sort to me"*.[70]

9.81 Likewise, a residential child care officer (RCCO) who worked in the Aviemore group (1970–1974) never witnessed any ill treatment and said the children "*were well cared for*".[71]

9.82 WN715 (Superintendent, 1973–1974) did not witness "*any physical or sexual abuse or was not informed of any*".[72]

9.83 WN870 (1973–1974) was not aware of any sexual abuse. She was not aware of any cellar and said that none were in use when she was there.[73]

9.84 The following staff said that they never witnessed or heard of any abuse:

- A member of staff who worked in the Home for six months in 1970.[74]
- A member of staff who worked at the Home between 1970 and 1974.[75] She was never approached by a child with disclosures of sexual abuse.

[68] Day 81/115
[69] Day 76/137
[70] WS000568/3
[71] WS000568/3
[72] WD006780
[73] WD006782
[74] WD006955
[75] WD006730

- Another staff member (1972–1973) told the police the same.[76]
- A part-time member of staff (1976–1979) did not witness any sexual or physical abuse but says that she was aware of bullying.
- WN661 (1976–1984) worked throughout her time in the Claymore group and did not remember any of the staff in her group physically abusing the children; she found it difficult to comment on other groups because she did not see them during the day. She said that no children complained to her about ill treatment.[77]
- WN520 (early 1970s) recalled the Home being a happy place and said "*I did not know of any hitting … nothing was going on as far as I am aware*".[78]
- A non-care member of staff who worked at the Home from 1981 said that she never saw any form of abuse.[79]
- WN871 (1974–1976) "*never saw anything untoward or ever felt 'bad vibes' about the Home*".[80]
- WN831 (1977–1978) did not recall seeing any instances of abuse, but said that she was outspoken and staff knew that she "*would not tolerate any wrong doing or injustice"* if she witnessed it.[81]
- WN102 (1978–1982)[82] said that she never used physical force on children and never saw any other member of staff assault them. She recalled that *"restraint techniques were sometimes used if a child was uncontrollable*" – holding onto the arms or legs to stop the child injuring themselves and others.[83]
- WN689 (1977–1979) considered the Home to be well run.[84]
- WN722 (1982–1984) said that she could not recall seeing anything inappropriate and never saw any child being verbally abused or restrained.[85]

[76] WD006954
[77] WD006777
[78] WD006940
[79] WD006799
[80] WD006731
[81] WD006790
[82] WD006810
[83] WD006810
[84] WD006785
[85] WD006957

9.85 A care worker in the Aviemore group worked for five years in the Home and never witnessed any abuse or heard any child complain of assault. She said that teenagers "*were restrained by placing arms around them*".[86] In her statement, given in April 2008, she also said that "*sometime recently"* she had spoken to a former resident at the Home who had told her about assault and sexual assaults taking place there. She told her Manager at Children's Services. She was also informed by the former resident that Colin Tilbrook had told her mother that if she did not make a complaint, she would be able to see her children more.[87]

9.86 WN532 and WN587 said that in their time as Superintendent and Matron they were not aware "*or even slightly suspicious*" of any child being harmed or ill treated or abused "*in any way*".[88] They noted that when they arrived at the Home, there was no access at all to any underground area – the only little room was a "*sort of coal scullery type of building"* and they thought that it was through that building that the SOJP gained access to the "*cellar area"* in 2008. We note that a memo from WN532 to Charles Smith in January 1975 refers to members of staff inspecting "*the hole under the house*" looking for two boys.[89]

9.87 Fay Buesnel remembered that she spoke to Jim Thomson about the Jordans and others: *"Occasionally I would speak to him about people I felt were a bit harsh … maybe hit somebody with a spoon at the table … You would speak to them at the time and say "do not do that again or I will report you" … I did not put it on paper … I would say to him … I am a bit concerned about such and such and he would say well … Have you spoken to the person … And I'd say yes and how I dealt with it …. Jim was lovely … But hated confrontation of any kind".[90] She told the police that "no child ever told me anything that I did not deal with."*[91]

[86] WD006728
[87] WD006728/8–9
[88] WD006213/15
[89] WD002627
[90] WD006918
[91] WD006918

9.88 WN7 told the Inquiry[92] that he did not see any cruelty nor did he witness any sexual abuse, although he accepts that there could have been some. He never saw a member of staff hit a child. He did not see children placed in their underwear in the detention rooms. In his view staff were sufficiently monitored and senior staff would walk round around the building.

9.89 Children complained to WN704 having been made to take cold showers for wetting the bed. Although WN704 did not use this practice on children in her group, she did not report it because Jim Thomson "*would just say that this was the way the units were run and it had nothing to do with me*".[93]

9.90 When presented with a memo from 1975 that he wrote, WN714 said that he could not remember the memo, nor any child or member of staff involved or suspected of being involved in "*homosexual activity*".[94] He also said that the memo, despite being signed by him, would have been typed by somebody else.

9.91 Mario Lundy was at HDLG in 1985 and in the short time that he was there nobody raised concerns with him, and he said: "*I had absolutely no evidence to indicate that anything might have been happening.*"[95]

Individuals accused or convicted of abuse

Morag Jordan (née Kidd) [96]

9.92 As discussed in Chapter 8, many witnesses spoke about disclosing abuse by Tony and/or Morag Jordan. In 2010, Morag Jordan was convicted of eight counts of assault against children at HDLG and sentenced to nine months' imprisonment.[97] Five counts related to regular striking with her hand about the head or face of three young girls; one count to rubbing a girl's face in urine-soaked sheets after she wet the bed at the age of 14 or 15; one count to punching a girl aged 11 in the back with her fist; and one count to the assault of a boy aged between nine and 12 by taking off her wooden shoe and

[92] Day 66/21
[93] WD006775
[94] WD006725/14
[95] Day74/194
[96] WD002620 – she is referred to as both 'Kidd' and 'Jordan' throughout the documents
[97] WD002620

throwing it at his head. The sentencing remarks described her as "*cold, uncaring and spiteful*" and said that "*During the course of her duties to care for these vulnerable children, Mrs Jordan routinely picked on and bullied the three girls. She was a cold woman who resorted to her hands frequently and unnecessarily. There were strong suggestions from the evidence at trial that she particularly picked on one of the girls who spent the majority of her childhood at Haut de ta Garenne under the care of Mrs Jordan".*[98]

9.93 In evidence to the Inquiry, Morag Jordan denied the allegations put to her and said that she did not understand why it was the staff had made allegations that were not reported at the time.[99] She did not remember a rule prohibiting children under the age of 11 from being hit, and said that she would tap on the fingers and on the back of the legs.[100] According to Morag Jordan, when she struck a child, it would be in front of other members of staff. All staff raised their voices with the children.[101] She thought that if they had had rules, the staff would have had some structure for what they could or could not do. We note that, as set out in Chapter 4, there were, in fact, rules in place during Morag Jordan's tenure at the Home.[102]

9.94 Marion Robson found Morag *Jordan "extremely brusque … She was always ready to be critical and shout and put (children) down"*. Marion Robson thought that Morag Jordan was tolerated at the time because *"reporting procedures were much more vague … There was less guardianship over that sort of thing … It was a different climate, really"*. She never witnessed her mistreating a child, although she did see her smack children's hands with a serving spoon.[103]

9.95 Ernest Mallet described the Jordans as "*cruel, nasty bastards*". He never saw them abuse children but thought that the way they spoke to and treated the children was inappropriate. He recalled one episode when he witnessed the

[98] WD002620
[99] Day 94/148
[100] Day 94/91
[101] Day 94/128
[102] WD007183/22
[103] Day 76/102

couple being aggressive to a child; he intervened and was thanked by Jim Thomson.

9.96 WN636 remembered that Morag Jordan *"could not walk past the kids without hitting them ... (she) was always shouting at them … and slapping them on the head for no reason"*.[104]

9.97 WN570 never saw Morag Jordan react in anger with children and had no concern about her.[105]

9.98 WN584 remembered her as being very "*mouthy*" with the children, but did not see her hit children.[106]

9.99 WN159 worked in Braintree alongside Morag Jordan. She remembers that Morag Jordan shouted at children regularly in front of the groups, that she would speak close to their faces and poke them in the chest. She thinks she may have commented on this to other staff but adds she never stopped to watch her behaviour: *"I had nothing to compare her with … I just thought she could have dealt with it differently*".[107]

9.100 A Housemother (1970–1974) recalled seeing Morag Kidd slam a sliding van door onto a 10-year-old boy's hand, saying *"That'll teach you"*. She told the police that she did not report this to anyone because Morag Kidd was her senior.[108]

9.101 WN562 said that she confronted Morag Jordan about her giving a child a black eye[109] and went to see Colin Tilbrook. A contemporaneous record describes her complaining to Colin Tilbrook about the disciplining of the child WN38 but notes that "*staff here will continue to discipline him as normal*".[110]

[104] Day 81/27
[105] Day 110/26
[106] Day 110/26; WD006793
[107] WD006720
[108] WD006016
[109] WD006933
[110] WD003133

9.102 WN532, former Superintendent, remembered that Morag *"knew the routine ... she seemed to be a good member of staff and would organise staff parties and take the kids out quite a lot"*.[111]

9.103 WN7 told the Inquiry that Morag Jordan was a role model and he never saw her hit a child.[112] Likewise WN539 said: "*She seemed to be a good member of staff.*"[113]

9.104 WN704 (late 1970s) remembered that Morag Jordan expected all leaders and staff to deal with the children in the same way; in her own group, if one or two children misbehaved all of the children would be punished.[114]

9.105 **Finding:** A large number of former residents and former staff members of HDLG gave evidence, either to the SOJP or directly to the Inquiry, about Morag Jordan's harsh treatment of children. Although some spoke positively about her, the weight of the evidence and the criminal conviction demonstrates that she picked on, bullied and assaulted residents at the Home. Several staff members reported having seen Morag Jordan assaulting children and a small number (such as WN562 and Ernest Mallett) say that they reported her to the Superintendent at the time. Despite this, no corrective action was taken against Morag Jordan. There was no disciplinary process and no recorded warnings. We consider this to have been an inadequate response, even taking into account the absence of policies and procedures for responding to allegations.

Tony Jordan

9.106 In 2010, as part of the same trial as his wife, Tony Jordan was convicted of eight counts of assault against children in his care and was sentenced to six months' imprisonment.[115] These included:

- A series of assaults against two young boys by striking them on the elbow with a knife or metal spoon when they were at the dinner table.

[111] WD006800
[112] Day 165/120
[113] WD006800
[114] WD006776
[115] WD002620

- Striking a boy over the head with his shoe because he failed to clean his shoes, and striking the same boy across the face with his hand, knocking him to the floor, because the boy refused to eat his lunch.
- Regularly hitting a boy across the face for a variety of reasons, including leaving the table without asking, not finishing food or being cheeky.

The sentencing remarks described him as a "*bully*" and highlighted a pattern of Tony and Morag Jordan committing "*repeated acts of casual violence against these children*".

9.107 In his evidence to the Inquiry, Tony Jordan said that he always disciplined a child in the presence of other staff. Jim Thomson, he was sure, would have been aware of his approach to discipline. He could not remember having disciplined a child in anger nor having seen others do so.[116] He saw other members of staff flick spoons at children's elbows; his actions were the same as the other staff he worked with in Claymore.[117] He added that he never punched a child in the solar plexus and never put WN22 in the detention cells, as were alleged.

9.108 Marion Robson recalled seeing Tony Jordan holding a boy up against the wall by the neck: "*I said something to him or tutted or expressed some disapproval and that was about it.*" She felt unable to intervene and did not think it her place to tell her father, Jim Thomson. She said that she hoped her father would have known about the Jordans.[118]

9.109 WN661 said that she saw Tony Jordan hit a child on the back of the hand with a spoon, around 1984, and told him she never wanted to see him do that to a child again. She could not remember if she reported the matter to the Superintendent but said: "*I never saw Tony hit a child again whilst I was there.*"[119]

9.110 WN704 said that she challenged Tony Jordan on a number of occasions about his treatment of the children. She gave an account of one particular

[116] Day 94/24
[117] Day 94/31
[118] Day 76/113
[119] WD006777

incident. He picked up WN125 from the floor by the scruff of the neck then let him go so that he fell to the floor. She confronted him and he just "*shrugged*", saying something like "*he should be playing with children his own age*". She reported the incident the next day to Fay Buesnel and another member of staff, WN706. As a result of this, WN704 believes that Tony Jordan was moved from Claymore group to Braintree group.[120]

9.111 WN570 saw Tony Jordan in the presence of children, but never had any concerns about his approach.[121]

9.112 **Findings.** In our view, the weight of the evidence and his criminal conviction confirms that Tony Jordan bullied and physically assaulted children for whom he was supposed to be caring. This was witnessed by staff members, some of whom did not report this behaviour. Where Tony Jordan's treatment was reported, it would appear that some action was taken. However, there is no contemporaneous record of this and no disciplinary proceedings were instigated.

9.113 Tony Jordan, like his wife, was allowed to continue in his role and to continue mistreating children. They were "hiding in plain sight". The fact that no action was taken in respect of Tony or Morag Jordan's conduct was reprehensible, whether judged by the standards of the day or of the present.

9.114 We consider that the absence of any appropriate response to Tony and Morag Jordan's physical abuse represents a serious failure of management to protect children in their care.

WN514 and WN515

9.115 WN514 and WN515 were both interviewed by the SOJP during Operation Rectangle in respect of the allegations of abuse made against them during the investigation. There were no allegations made contemporaneously and therefore, as above, no findings are made. In their first interview in

[120] WD006776/4
[121] Day 110/27

December 2008 they stated that they never physically punish the child and never caned a child.[122]

9.116 During a second interview in January 2009, both denied all of the specific allegations of abuse that were put to them. In respect of an allegation that WN514 shook a girl and knocked a jug of boiling water over another child she said she recalled the incident. She did not recall if she was present or was told by another member of staff that it had happened. Contemporaneous records do not indicate any involvement of WN514.[123]

9.117 In the SOJP report on the allegations,[124] the interviewing officers considered that it was "*quite clear"* that WN514 and WN515 were lying during their interviews and had spoken and come up with the same stories. DC McGranahan noted that: "*They would have police believe that in an eight-year period at HDLG during some of which time they had been [in a senior role] of the home that nothing untoward had gone on. There were no instances of children being given a clip round the ear for being naughty, no child ever being put in detention whatsoever unless on the say so of a court and no child ever being deprived of food or given the cane."*

Richard Owen

9.118 In 1998, Richard Owen was convicted of one count of buggery and four counts of sexual assault on young girls at the residential school in which he worked after leaving HDLG. The school was run by staff members previously employed at HDLG.[125] As noted elsewhere, he also had a conviction for indecent assault before joining the staff at HDLG in the 1970s.

9.119 Fay Buesnel told the police there were rumours at the time that Richard Owen had a relationship with a girl at HDLG.[126] WN636 (1974–1976) recalled seeing him in town with his arm around WN183 but does not say

[122] WN514–WD006768, WD006713, WD006714; WN515–WD006293, WN066296
[123] WN514–WD006715, WD006716; WN515–WD006927
[124] WD001527
[125] WD006747
[126] WD006921

whether she reported this.[127] WN694 "*often felt"* that Richard Owen "*could get physically too close to all the girls including* [WN183]".[128]

9.120 WN532, in a statement to the police in 1996, said that there was one matter of concern at the time, namely young female residents visiting Richard Owen's flat in HDLG to babysit. He mentioned this to WN587 but they took it no further, deciding that as Richard Owen was married "*no harm was being done*".[129] He recalled that WN183 babysat for Mr and Mrs Owen.

9.121 WN705 knew WN183 while both were at HDLG, during which WN183 never disclosed that Richard Owen sexually abused her. WN705 subsequently came into contact with WN183 after they had both left HDLG and WN183 told her that she had had a sexual relationship with Richard Owen but did not want anyone else to know. WN705 said that she was "*deeply concerned about the possible implications of when the relationship was started or fostered. Either way it would have been inappropriate childcare*".[130]

9.122 WN183 gave evidence at Richard Owen's trial in 1998, giving an account of how he sexually assaulted her while she was at HDLG. She declined to make any complaint to the SOJP at that time.[131]

9.123 **Finding:** Despite rumours and concerns among staff about Richard Owen during his time at HDLG, nothing was done about this. We consider that this was inadequate – children were left at risk of sexual abuse.

WN530 and WN531

9.124 WN530 and WN531 both denied all the allegations of sexual abuse there were put to them.[132]

Senior member of staff

9.125 The SOJP interviewed a former senior member of staff in 2009.[133] He said that he was appalled at the allegation he buggered WN171. He remembered

[127] WD006721/7
[128] WD006789
[129] WD006749
[130] WD006556
[131] WD006747
[132] Day 134/107

WN171 as being "*very, very disruptive*" and said that he disciplined him for stealing money from a member of staff; he made him pay back the money from his weekly pocket money allowance. Allegations of physical assault were also put to him, to which he replied that he never physically assaulted a child in his care. He asserted that he was against the use of corporal punishment from the outset of his time in child care.

WN570

9.126 WN570 was the subject of several complaints during Operation Rectangle, predominantly of common assault but also one allegation of indecent assault and a complaint of cruelty.

9.127 An allegation by WN98 was reported contemporaneously. When WN98's mother saw bruising on her arms she phoned HDLG and the CCO, Richard Davenport. She said that she was told that WN570 had been given a good telling off and a warning.[134] A memo written by WN532 to Charles Smith in May 1975 recorded an account of WN98 having bruising to her upper left arm caused by WN570.[135]

9.128 In evidence to the Inquiry[136] WN570 said that she remembered being reprimanded by Charles Smith but there was no written reprimand. She recalled a memo that was sent around after the incident to remind staff not to restrain children. WN570 denied using excessive force in restraint and said that she caused a single bruise, a thumbprint, on the child's upper arm. On reflection, she said that she should have handled the situation differently but there was no training and she acted "*on the spur of the moment*".[137]

9.129 WN570 denied the following allegations:

- That she was one of the members of staff who assaulted WN99 when camping.[138]
- That she beat WN99 in a detention cell.

[133] WD006719
[134] WD005866
[135] WD002687
[136] Day 110, WS000666, WS000667, WD005863, WD005869, WD005864, WD005865
[137] WS000667/3
[138] WD002811

- That she made WN6 stand outside the bedroom all night as punishment. WN570 said that the girl was not in her group and she did not have anything to do with her.
- Any allegation of indecency made by WN139 in relation to a tampon and an allegation that she hit WN50 with a hairbrush.

9.130 WN636 (1974–1976) remembered WN570 as being firm but fair and respected: "*She had a good relationship with the children.*"[139] WN694 (1974–1976) also remembered WN570 being good at her job and very professional. Another staff member (1973–1975) thought that she dealt with the children in a firm but fair manner.[140]

9.131 **Finding:** In our view, the response to this complaint of physical assault was adequate. There were no policies and procedures in place, but following a complaint from the child's mother, this was recorded, passed to the CO, and led to a verbal reprimand.

WN503

9.132 During Operation Rectangle, WN503 was the subject of allegations from eight former residents at HDLG in relation to physical assault and/or cruelty. She denied all the allegations.

9.133 One allegation related to WN503 striking WN127 in the face, possibly with a hairbrush. A contemporaneous memo from Jim Thomson to Charles Smith in October 1977 referred to an incident three months beforehand, which WN503 reported to Jim Thomson at the time. He stated: "[WN127] *either struck or attempted to strike* [WN503] *who reacted automatically self-defence*". The memo also noted WN127's mother's allegation that her daughter suffered hearing damage as a result.[141]

9.134 When interviewed[142] by the SOJP in January 2009, WN503 spontaneously recalled slapping WN127 across the face following verbal abuse and said

[139] WD006724
[140] WD006802
[141] WD005961
[142] WD008754

that she was slapped back in return. She said that WN127's mother complained, WN503 apologised and the matter was treated as over. In a subsequent interview, in February 2009,[143] WN503's account differed as to who struck the first blow. On this occasion, she said WN127 hit her, so she hit her back. She described the incident as a blur.

9.135 **Finding:** We do not make any finding as to what actually happened in the incident but note that it was self-reported by WN503 at the time. Following a complaint by WN127's mother about the incident, Jim Thomson informed Charles Smith, the CO, and noted that they were getting a medical opinion. Although we do not know what, if any, action was taken – we consider that the fact that it was recorded and passed to the CO was appropriate.

Fay Buesnel (Campbell)

9.136 During Operation Rectangle, six complainants made allegations against Fay Buesnel, two of whom did not pursue them. She denied the allegations against her and gave the following, more general evidence:[144]

- Smacking was acceptable by the standards of the day and she saw other staff do it if a child misbehaved and it was absolutely necessary. She denied doing it herself.
- Caning was done exclusively by the Superintendent and recorded, with the CCO notified in advance. She never sent a child to be caned and was never present when the cane was administered.
- Children were restrained if they were violent towards others or "*running amok*". She was involved sometimes but, being small and skinny, she sometimes got hurt.
- She did not have to hit children because she had a presence which stopped them misbehaving when she was on duty.
- Detention could only be authorised by the Superintendent and for a maximum of 24 hours.[145]

[143] WD008756
[144] WD006915, WD006915, WD006787, WD006916–WD006922
[145] We note that, during Fay Buesnel's time at the Home, children were recorded as being placed in detention for more than 24 hours

- Children, if disruptive, were asked to stand in the corridor for ten minutes to calm down, but she had no part in this.

9.137 Former members of staff gave the following views on Fay Buesnel:

- Ernest Mallett described her as a "*brilliant caring person*".
- WN694 described a "*kind of Cruella De Ville*". [146]
- A carer who worked at the Home for six months recalled her as "*a very harsh, unapproachable woman*" but she never saw her do anything untoward against the children.[147]
- WN7 thought she had a good, fundamental knowledge of child care.[148]

WN7

9.138 The allegations made against WN7 are set out in detail in Appendix 2 and considered in Nicholas Griffin QC's report (Chapter 11). In evidence to the Inquiry, WN7 denied the allegations of abuse made against him and said he believed the "*vast majority*" were made for compensation. It was important, he said, for the Inquiry to be aware of the background of some of those making allegations against him.[149]

9.139 One part-time member of staff remembered WN7 being "*young and lively and very popular with the kids*".[150] Another, WN102, thought him firm but fair and never saw him hit anyone.

9.140 The Inquiry has not obtained any records showing contemporaneous allegations made in relation to WN7's time at HDLG, and therefore no findings are made in this chapter in that regard.

WN552

9.141 WN552 was accused of a single instance of physical assault. When asked whether she injured WN146 so that he needed hospitalisation, she had no recollection of anything concerning WN146. A memo from WN532 to Charles

[146] WD006789
[147] WD006677
[148] Day 65/129
[149] Day 66/53
[150] WD006796

Smith dated September 1974 recorded an injury to WN146's finger and his going for a check-up.[151]

9.142 WN552 recalled accidentally closing the door of a mini-van on a boy's hand but could not remember if he went to hospital. She thought she would have reported it at the time.[152]

9.143 WN636 remembered WN552 and WN146 playing with a rugby ball; WN146 bent his finger back, went to hospital and the finger was put in a splint.[153]

Gordon Wateridge

9.144 Gordon Wateridge (1970–1974) was a Housefather at HDLG, in charge of the Senior Group.

9.145 In 2009, he was convicted of one count of assault on a boy and eight counts of indecent assault on three girls in their early to mid-teens. He was sentenced to two and a half years' imprisonment.[154] The Royal Court observed that "*The victims were children who were vulnerable due to their position. They were fully entitled to expect care, love and kindness yet they received sexual bullying and unkindness*". However, the Court stated that "*it must be careful not to blame Wateridge for the damaging experiences the victims had been subject to by other persons".* Gordon Wateridge was the only former staff member from HDLG to be convicted of sexual offences arising out of Operation Rectangle.

9.146 In his statement to the Inquiry, Gordon Wateridge refused to deal with most of the allegations of abuse made against him, including some made for the first time to the Inquiry, and despite his convictions stated: "*All the allegations are rubbish and complete nonsense.*"[155] He said that some children alleging abuse were not even at HDLG and he was never alone with the children.

[151] WD006673
[152] WD006938
[153] WD006724
[154] WD001202
[155] WS000742

9.147 In an interview with the SOJP, Gordon Wateridge had said that he had been spoken to by Colin Tilbrook for having "*tore a strip off one of the kids",* leading to at least one child complaining.[156] In his statement to the Inquiry, he said that he had meant that he would tell children off if they were misbehaving.

9.148 There is evidence to suggest that Gordon Wateridge was dismissed by Colin Tilbrook in the early 1970s after he assaulted another member of staff.[157] Gordon Wateridge denied this and said that he left because he was fed up with HDLG. He was frustrated that he had not had the opportunity to complete the Home Office training course and told Charles Smith "*to stuff his job*".[158]

9.149 Education Committee minutes for November 1973 note an allegation that Gordon Wateridge assaulted a boy at HDLG. "*In the event of the allegation being proved, Mr Wateridge should be dismissed forthwith*". The CO was instructed to investigate.[159] There is nothing further relating to this in his personnel file. Gordon Wateridge said the allegation was never raised with him at the time and was not the reason for his departure. He thought that the records kept about him were inaccurate and was clear in his mind that he left in March 1973 after working a one-month notice period.[160]

9.150 We note that despite Gordon Wateridge's evidence on this point, the contemporaneous records suggest that he was still employed in January 1974 and was applying for other roles, with references provided by the States of Jersey. One such reference, authored by the Director of Education at the time, notes that Gordon Wateridge does not share the same outlook as the new Superintendent, and he felt that this was the reason for them seeking a change.[161]

9.151 **Findings:** Although the evidence is incomplete, there were contemporaneous complaints made about Gordon Wateridge physically assaulting children at the Home. Initially, these were dealt with by Colin

[156] WD005892/15
[157] WD005899; WD006672
[158] WS000742/15
[159] WD001203
[160] WS000742
[161] WD001203/4–5

Tilbrook having "words" with him, however at one stage the allegations were passed to the Education Committee and the CO was instructed to investigate. This, as an initial response to an allegation of assault, was adequate, however there was no evidence before the Inquiry as to whether an investigation in fact took place.

9.152 The real reason for Gordon Wateridge's departure from the Home is not clear – whether it was his own decision, due to assaulting a member of staff, due to assaulting a child, due to a difference of opinion with the new Superintendent, or some combination of these reasons. However, we consider that the Director of Education's positive references for Gordon Wateridge, with no mention of the complaints made against him, was professionally irresponsible and amounted to an inadequate response to the allegations.

WN562

9.153 WN562 was the subject of allegations of indecent assault and physical assault during her time at HDLG. When interviewed by the SOJP in January 2009 she gave a "no comment" interview.

9.154 WN602 said in her witness statement[162] that WN562 had boasted to her of having sex with older male residents of HDLG, but she was not sure that she believed these tales.

WN520

9.155 WN520 was the subject of allegations of indecent assault. According to his account, WN715 told him that a girl had alleged he touched her when he tucked her into bed. He told WN715 he "*did not do it, complete rubbish*". Charles Smith, he said, investigated the matter "*and it turned out that it was total fabrication".*[163]

9.156 WN520 said he was instructed by WN715 not to speak to other staff members. He was not suspended and was eventually exonerated. He said

[162] WD006913
[163] WD006939

no male staff member would put children to bed or take a female resident[164] to the toilet. He told the police he left HDLG voluntarily.

9.157 WN715 said he never referred an allegation of this type to Charles Smith or the Committee. A serious matter such as this would have "*been referred upwards by me, I would not have dealt with any allegations of this sort*".[165]

9.158 The Inquiry does not have any contemporaneous records of the allegation being made or of any investigation being carried out. There are conflicting accounts and, as a result, we do not make any findings, but observe that, had the matter been referred to the CO for investigation, this would have been an appropriate response.

WN636

9.159 WN636 was interviewed by the SOJP in response to an allegation that she had had a sexual relationship with WN377, a male resident. In her statement, she said that she had "*definitely not*" had sexual relations with WN737 or other boys at the Home.

Marion Robson

9.160 In 1984, Marion Robson was disciplined for slapping a child in the face, "*to allow him to calm down*". She set out the circumstances in a memo to Terry Strettle, CO, in which she expressed regret for having slapped WN747. The issue was dealt with by way of an oral warning given by Terry Strettle and recorded in a letter which concluded: "*I hope your future work will show that it was an isolated act resulting from a particularly stressful situation and a lapse of control.*"[166] She was warned that should a similar incident occur, the matter would be reported to the Director of Education who would decide whether to suspend her and report the facts to the Education Committee. This implies that this incident was not reported to the Education Committee.

[164] WD006942; WD006943
[165] WD006781
[166] WD005774

9.161 In evidence to the Inquiry she denied all allegations of physical abuse and added that she never restrained a child nor witnessed one being pinned to the floor.[167]

9.162 **Finding:** We consider that this was an adequate response to an allegation of physical assault. Although we do not have sufficient evidence to extrapolate any further, we note that a relatively low-level physical assault led to a discussion at a high level, a warning that was confirmed in writing, and the threat of further procedures being instigated if there was any reoccurrence.

Mario Lundy

9.163 Most of the evidence on Mario Lundy's response to the allegations of abuse made against him is dealt with in the section below on Les Chênes/Greenfields. There were no contemporaneous allegations of abuse and therefore no findings are made in this chapter.

9.164 In relation to the allegations of abuse made against him with regard to his time at HDLG, he said:[168]

- He never picked up a resident by the ears or punched one in the stomach.
- The allegation made by WN383 that he saw him grab a girl by the throat, push back against a wall and punch in the face, never happened.
- He never poked children in the chest, saying "*Go on, hit me*". He said "*If a young person was coming at me I would have stood my ground and been quite assertive.*"
- He did not throw WN36 and WN591 against a wardrobe before throwing them onto their beds and did not recognise that scenario at all.
- In relation to WN391, he told the Inquiry: *"at some stage if I was dealing with a bully or someone who have been aggressive or abusive to a member of staff or another young person, I would give them a good ticking off and I may well have been wagging my finger when I was doing it".*
- He did not recognise at all the account of his lashing out and hitting WN91.

[167] Day 76; WS000583
[168] Day 75; WS000587

Non-staff members accused and/or convicted of abuse

Anthony (Tony) Watton

9.165 Tony Watton did not work at HDLG but did have access to children there, by virtue of a relationship with Morag Kidd (as she then was) and a link with some of the residents. He used to volunteer in the evenings, visit the children at the weekends, and apparently was involved in taking holiday camps. He also ran the Jersey Canoe Club but following allegations of abuse in 1979, he was asked to resign from this position.

9.166 He was convicted in 1987 of indecent assault unrelated to HDLG. In another police investigation in 1996 he admitted being a paedophile.

9.167 In 2001, Tony Watton was charged with indecently assaulting two boys during the 1970s and 1980s, including one at HDLG. He committed suicide while on bail in November 2001.[169] Other allegations were subsequently made of sexual abuse by Tony Watton during Operation Rectangle.

9.168 Other staff members who were asked about him said the following:

- WN570 knew Tony Watton and would see him when he came to visit children at the Home. She had no concerns about him.[170]
- Fay Buesnel remembered Tony Watton spending a lot of time at the weekends at HDLG.[171]
- Morag Jordan recalled that Tony Watton used to volunteer in the evenings and used to take some of the children canoeing. She says that there was nothing about his behaviour that caused her concern at the time, but looking back "*perhaps something was not quite right".*[172]
- It would appear that there were no contemporaneous allegations of abuse made about Tony Watton during the period in which he was visiting children in HDLG.

[169] WD004365
[170] Day 110/27
[171] WD006919
[172] WS000621/10

Terence Jarrett

9.169 In May 1972, Colin Tilbrook wrote to the Children's Office setting out the steps taken following disclosure by two boys that they had been indecently assaulted by a Terence Jarrett (a visitor to the Home). One boy stayed overnight at the Jarretts' house. Colin Tilbrook talked to the boys and satisfied himself that "*there was a prima facie case for further investigation*". With Charles Smith's approval, Colin Tilbrook met with DC Watkins at Charles Smith's office. The police officer determined that "*as Mr Jarrett had a previous conviction (when he was aged 14) he would take statements from the boys". He later arrested Mr Jarrett who was charged and brought before the Police Court Magistrate".*[173]

9.170 Someone closely connected to Terence Jarrett had previously worked at HDLG, leading Colin Tilbrook to conclude, in respect of any possible vetting of visitors: *"any investigation into* [the family's] *background was never at any time indicated. I would not like to see that this isolated incident, serious although it may be, should make it necessary for the parents of any of the children's school friends to be subjected to any kind of prior investigation*".[174]

9.171 There is no record of whether the boys' welfare was followed up following this episode, although by the standards and knowledge of the day, it is unlikely that follow-up would have been routine and/or thought necessary.

9.172 Colin Tilbrook complained to Charles Smith about the *Jersey Evening Post* (JEP) naming the children in their report of the case "*in direct contravention of the Children (Jersey) [1969] Law, Article 44".* He asked the new CO to deal with the paper "*more firmly*".[175]

9.173 **Findings:** We conclude that the response to these allegations of abuse was adequate. Colin Tilbrook talked to the children about their disclosure. He then passed the matter on to the CO, and they decided between them, to notify the police. In the absence of formal procedures, this was an appropriate response to a disclosure of sexual abuse.

[173] WD001239
[174] WD004362
[175] WD008616

WN973

9.174 In November 1972, allegations were made by WN121 that he had been abducted from HDLG by an individual called WN973. He said that WN973 took him to his flat and sexually assaulted him, although he did not recall much as he was "*drowsy*". The police found him and WN973 was arrested and convicted. WN121 said that he was taken back to HDLG and placed in the detention room for two weeks. As he recalled it, it was so that he could not tell the other children what had happened.[176]

9.175 As recalled by WN121, the matter was in fact reported to the SOJP, who interviewed staff members at the Home. The interviews provide some insight into the attitude, at the time, towards visitors to HDLG.

9.176 Margaret Davies (Tilbrook) said in her statement that because of WN121's circumstances she liked to be informed regarding visitors. She therefore "*accosted*" WN973 when she saw them together on an earlier occasion, concerned that he had entered the premises without authority. However, she then discovered that he had asked for WN121 on entry to the Home. She told WN973 that if he wished to see WN121 again, he should make a "*proper*" appointment. He did so and saw WN121 10 days later during which time a staff member was present.[177]

9.177 Gordon Wateridge, in his statement from the time, said that he was also under the impression that an appointment had been arranged through the Superintendent's office, but later learnt this not to be the case. The next time WN973 visited, he had made an appointment and Gordon Wateridge was present throughout the visit. He asked Gordon Wateridge whether WN121 would be able to work in his shop again, but Gordon Wateridge explained that in the circumstances this was not possible.[178]

9.178 WN664 provided a statement in which she said that she was on night duty during the night when WN121 had been taken. She did a dormitory security

[176] WD000678/118
[177] WD006451
[178] WD006452

check and later, WN162 told her that WN121 had been taken and had been given money. She called the police.[179]

9.179 The actual nature of the offence itself is set out in a memo from the Superintendent (Colin Tilbrook) to Charles Smith.[180]

9.180 WN973 was initially charged with:

- breaking and entering;
- inducing a child to escape from a detention home; and
- indecent assault.

The first and third charges were withdrawn and he was imprisoned for one month after being convicted of the second charge. [181]

9.181 **Finding:** In our view, the staff at the Home responded appropriately by involving the SOJP when WN121 was abducted. If WN121 was placed in the detention room upon his return in order to prevent him telling other children, this was clearly wrong.

Henry Fleming

9.182 As noted elsewhere, concerns were raised in the mid-1970s about a man called Henry Fleming, who lived near HDLG and was interacting with residents.

9.183 On 29 July 1975, Jim Thomson, then SCCO, in a memo to WN532 (Superintendent at the time), recorded a visit he made to Henry Fleming with Richard Davenport, a CCO: "t*he purpose of the visit was to meet personally this man who has been involved over many months in dealing with our children from Haut de la Garenne; quite a few of whom have been making a habit of visiting him and reputedly receiving cigarettes and drink".* Henry Fleming admitted that he had given cigarettes to the children named in the memo. The memo referred to a bunker that had been decorated and furnished by Henry Fleming. Jim Thomson noted: "*it may well be that his*

[179] WD006455
[180] WD001656
[181] WD006453, WD001656

motives are entirely innocent but homosexual malpractices cannot be discounted … I intend pursuing further enquiries about this man … It would also be advisable to place this property out of bounds to our children."[182]

9.184 In a statement dated 2 August 1975, Henry Fleming admitted to the police that he engaged in sexual activity with children from the Home.[183] In a subsequent statement, he said that the children visiting him engaged in sexual activity with each other, despite being under age.[184]

9.185 Henry Fleming described how he had indecently assaulted children over a period of two or three years. In return, he would give them cigarettes and alcohol. One assault resulted in WN344 having to be medically examined.

9.186 On 5 August 1975, WN532 wrote a memo to Charles Smith, noting that he had reported Henry Fleming to the Constable, and saying: "*we have repeatedly tried to discourage children but this man's temptations have been too strong*".[185] A memo dated two days later notes: "*it now seems that some of our children are very seriously involved with this man. I wondered if any further involvement with C.C.O.s is necessary in case parents become aware and question happenings.*"[186] He noted that WN136 had admitted regular visits and at least one indecent offence, WN334 admitted regular visits and at least one gross indecent offence, while others were fringe observers and "*occasionally involved in mild sexual offences".*

9.187 In October 1975, Henry Fleming was sentenced to two years' imprisonment for indecent assault, gross indecency, exposure, and attempts to procure the commission of an act of gross indecency. An SOJP report from September 1975 summarise the charges and the investigation.[187]

9.188 There are few documents available to the Inquiry to show what, if anything, was done within HDLG or by Children's Services following the conviction of Henry Fleming. The statements given by the children to the police recorded

[182] WD001165/2–3
[183] WD00165/6
[184] WD001165/8
[185] WD000897
[186] WD000898
[187] WD005783

that each child was accompanied (at the time of giving the statement) by a member of staff from HDLG, including WN532 and WN587. There is no record of whether the children involved exhibited any distress.

9.189 WN694 remembers children going to Henry Fleming's house, saying: "*We never let any of the kids from our unit go.*"[188]

9.190 **Findings:** We note that children had been visiting for a period of several months before any investigations were carried out. There was, at the very least, awareness that the children had been visiting and receiving alcohol and cigarettes from a man in his sixties. By early-August 1975, there was a recognition of sexual assaults on several children resident at the Home, however it was only reported to the Constable when initial attempts to discourage the children from visiting had failed. We consider that the response to concerns was inadequate. Those responsible for the care of the children failed in their duty to take adequate measures to protect those children from sexual abuse.

9.191 We note that there was an investigation carried out by Children's Services, that was then reported on to the Constable, and that this led to prosecution of Henry Fleming.

9.192 We deprecate the apparent reluctance to inform parents that their children had been the victims of sexual abuse – the memo noting that CCOs should be involved "*in case parents become aware and question happenings*" suggests that there was no plan to inform them. We consider that this was inadequate and we are critical of the possible motivation – to protect reputations.

<u>Allegations against religious figure(s)</u>

9.193 One staff member between 1974 and 1976 commented that a religious figure wanted to take the children camping after having turned up without

[188] WD006789/5

appointment or introduction. They stopped this plan, told the police and he believes that the religious figure left the island.[189]

9.194 Two other staff members, WN714 and WN668, also gave evidence about a religious figure coming to the Home around 1975/1976 as a volunteer.[190] WN714 says that he did not know where he came from or who appointed him and that after he had left, his wife, WN668, told him that he had grabbed her and tried to put his hand down her skirt. WN668 said that she was always suspicious of this man and felt uneasy around him – saying that he would make inappropriate comments to her and one day grabbed her breasts and tried to put his hand down the front of her skirt. She did not tell anyone and did not see him again after that incident.

9.195 Another staff member gave evidence about the religious figure and was under the impression that he was on some sort of placement. He says: "*My impression of him was that he was a very dangerous person. He made the hairs on the back of my neck stand up.*"[191]

9.196 Due to the absence of contemporaneous records, we do not make any findings on these allegations.

Residents accused and/or convicted of abuse

Michael Aubin

9.197 Michael Aubin was charged in 2008 with offences of sodomy, gross indecency and indecent assault on three boys. The offences took place in 1978, when Michael Aubin was resident at HDLG.[192] In 2009, Michael Aubin pled guilty to two counts of procuring an act of gross indecency, and two counts of indecent assault. It was noted that *" … there had been an element of cruelty in the circumstances of this case. Not cruelty by the Police who arrested Aubin, nor by the Attorney General for prosecuting him, because that had to be done … but cruelty in the circumstances. The defendant was entrusted into the care of the State when he was three. The State was in*

[189] WD006425/5
[190] WD006424 and WD006423
[191] WD006789/5
[192] WD003591, WD003592, WD003593, WD005784

loco parentis. He became what he became in the care of the State and now the State comes after him thirty-two years later to prosecute him for what he did when he was in its care, aged fourteen, a disturbed, brutalised fourteen year old".

9.198 There are various examples, between 1976 and 1978 of Children's Services' response to reported incidents:

- April 1976: two children in a state of undress were found in an outbuilding with Michael Aubin. Charles Smith noted: "*We have once more to put the boy under close supervision.*"[193]
- August 1977: Michael Aubin made advances to a young boy in his bed. Jim Thomson's memo to Charles Smith noted: "*Remove from group dormitory situation and spend the rest of his leave sleeping in detention; I have not decided if he will be locked in, and I am in agreement with Mr Skinner that steps should be taken for his admission to the Boy's Hostel as soon as possible after he has finished his schooling.*" Jim Thomson also noted: "*The most worrying thing is that he is prepared to make advances to young boys.*"[194]
- September 1977: Memo from Jim Thomson to CCO noted that Michael Aubin is "*under supervision of a member of staff for the last few days of his leave, and if this is not possible he should be confined to the detention room*".[195]
- May 1978: Memo to Charles Smith from Jim Thomson that Michael Aubin made "*sexual overtures to a boy*". Arrangements were made to interview "*the parties concerned*" and boy's mother informed – it was noted that this "*may have been premature because she became overexcited and upset and ended up discharging [the boy] from care*".[196]

[193] WD001444
[194] WD001441
[195] WD001487
[196] WD001465

- July 1978: Memo from Jim Thomson to SCCO regarding "*Further incident with homosexual overtones … Strongly advised transfer to an environment where he does not have ready access to young boys*".[197]

9.199 **Findings:** We acknowledge that Children's Services were placed in a difficult position in how to respond to this abuse. They had to balance the needs of the victims with the needs of Michael Aubin, all of whom were in their care.

9.200 We consider that Children's Services did try and prioritise the safety of the victims, by placing Michael Aubin under close supervision and even locking him away. Nonetheless, they failed to take sufficient safeguards, and Michael Aubin was able to continue sexually assaulting children over a two-year period.

Other residents

9.201 There is evidence in relation to other residents of HDLG accused of abuse against fellow residents, either contemporaneously or subsequently:

- WN43: memos from 1980 refer to WN43 making sexual approaches to younger children. Jim Thomson noted that WN43 would continue to sleep in the detention room and night supervision was reviewed.[198]
- WN504: in 2010, a SOJP report recorded WN504 (resident) admitting his "*conquests*" with younger girls at the Home, including going to the girls' rooms to touch their private parts and stripping a girl on a camping trip. WN504 said these were acts sexual experimentation and that the girls were willing participants.[199]
- WN74: during Operation Rectangle, WN28 made allegations of WN74 and others (aged 17 or 18) would force younger children to perform oral sex on them and touch their genitals. It was noted that there was no

[197] WD001490
[198] WD000977, WD000941
[199] WD003504

contemporaneous support for these allegations and a number of inconsistencies in the accounts of abuse provided by WN28.[200]

Heathfield

WN637

9.202 In October 1987, WN36 reported to the SOJP that he had been indecently assaulted by WN637. WN36 (aged 17) had left Heathfield a month before and gone into foster care, while WN637 had left his role as a member of staff at Heathfield a few months previously and gone to work in a children's home in the UK. The matter was investigated by the SOJP[201] and in interview WN637 admitted to the conduct alleged but stated that sexual contact had been consensual. No charges were brought.

9.203 In a memo dated November 1987, after WN637 had left the employment of the Education Department, Anton Skinner said:

> *"Please note for future reference that* [WN637*] should not in any circumstances be considered for a position in employment or voluntary work with the Department that would involve contact with children. For further information, see Children's Officer or a Deputy who should defer to Child in Care file."*[202] [His emphasis]

9.204 Anton Skinner said, in evidence to the Inquiry, that he was unaware of any UK-wide mechanism for informing other potential employers about the risks posed by WN637. He made no enquiries as to where WN637 moved to and was unaware that when he left, he had been given a reference by Terry Strettle (previous CO) for a post where he would be working with young girls who had been sexually abused.[203] Anton Skinner noted that WN637 had not done anything that had been found to be criminal and said: "*I appreciated that this did not prevent him working with children elsewhere but I could do nothing to prevent that.*"[204] Subsequently, WN637 changed his name and obtained a job in the health sector in Jersey.[205]

[200] WD002635
[201] WD004695
[202] WD004684
[203] Day 87/161
[204] WS000614/29
[205] WD004687

9.205 **Finding:** After an initial investigation by the SOJP which led to no charges, the response of the Education Department was inadequate. Some action was taken in that Anton Skinner left a note on the file stating that WN637 should not be considered for employment or voluntary work with children in Jersey.

9.206 However, this was, in our view, insufficient. No attempt was made to contact the children's home in the UK to which WN637 had moved with a reference from Jersey. It is clear from the file note that Anton Skinner considered WN637 to pose a risk to children, therefore the Education Department had a responsibility to take reasonable steps to prevent him working with children outside of Jersey as well.

WN335

9.207 In 1991, WN216, a former resident at Heathfield, alleged that he had been sexually abused by his key worker, WN335, over a period of several years.

9.208 In evidence to the Inquiry, WN335 denied the allegations and described them as fabricated.[206] He asserted that he did not give WN216 special privileges and that although he gave him driving lessons, gave him lifts to his flat, and helped him put up shelves, these were part of his role as key worker. He denied showering at WN216's flat, and drinking whisky with him at Heathfield. He accepted in hindsight that it was a misjudgement to arrange for WN216 to have a role connected with Heathfield after he left, but said he had spoken to staff who agreed it was appropriate. He thought that there were a number of possible reasons why WN216 had made the allegations, and gave some examples.

9.209 WN335 went on to say that he recalled WN216 having made vague comments about having been mistreated at HDLG before he came to Heathfield. He did not pass these comments on as he felt that they were a cry for attention and would only do so where there was clear evidence that the young person was telling the truth, which he acknowledged involved

[206] Day 84; WS000603

making a subjective judgement.[207] He did not recall any procedures, guidance or training in place for dealing with disclosures of abuse at that time. On reflection, he acknowledged that he perhaps should have referred WN216's disclosures to Anton Skinner before deciding whether or not to act upon them.[208]

9.210 Six members of staff at Heathfield were interviewed by the SOJP, as was WN335's wife. One staff member said that when WN216 disclosed to her that he was having a sexual relationship with WN335, she and other staff members informed Anton Skinner.[209] Sean McCloskey gave evidence to the Inquiry that following WN216's disclosure to him, he said that he would have to tell management, about which WN216 was unhappy. As noted above, he said that there was no guidance on responding to disclosures in place at Heathfield at the time.[210]

9.211 Phil Dennett, a member of staff at Heathfield at the time, recalled that the allegations were brought to his attention by a member of staff who visited him at home. He immediately contacted WN669, a staff member, and they went to see WN216. Once they were satisfied that WN216 had indeed made the allegations as described, they notified Children's Services. In his statement to the SOJP in 2008[211] he said that when a young person made a disclosure of abuse, his social work training taught him that it was not for him to question its veracity but to ensure that it was passed on to the appropriate person for investigation.

9.212 Following the disclosure of the allegations, WN335 was suspended by Anton Skinner, who referred the case to Detective Sergeant (DS) Adamson of the SOJP CPT. However, before the police investigation commenced, Anton Skinner interviewed WN216 and WN335 and two other staff members, Phil Dennett and WN669. On 4 April 1991, he wrote a 10-page letter to DS

[207] Day 84/24
[208] Day 84/54
[209] WD004531
[210] Day 69/170
[211] WD007345

Adamson containing his notes on the allegations, informing him of all that he knew on the case and setting out various conclusions of his own.[212]

9.213 In evidence to the Inquiry[213] Anton Skinner said: *"I did not see my involvement whatsoever as investigating the case, I was gathering the allegation."* He went on to say *"I wanted the matter investigated very thoroughly by the Child Protection Team … "* and he didn't want to engage in any way other than collecting the initial material to be handed over.

9.214 He agreed that it was unusual that he had allowed WN335 himself to inform the staff at Heathfield of the suspension.

9.215 Anton Skinner was referred to comments within his letter such as *"I asked why once WN216 was free of Heathfield … he allows WN335 to continue a relationship which he WN216 maintains he did not like"* and *"This I find to be a very weak explanation and it altogether does not fit unless [WN216] enjoyed the relationship"*. In response, he said that he did not endanger the police enquiry and was trying to share his *"impressions"* with DS Adamson.[214] It was not an attempt to prejudge the case. His *"layman's observations"* in the notes *"should not be accorded … any significant status"*.[215] He was not trained in interviewing young people who had made disclosures of abuse, and had not produced a similar document in the course of any other investigation.[216]

9.216 He accepted in evidence that it was not the role of the social worker to make a judgement about the veracity of allegations but to listen and explain to the child what was going to happen.[217]

9.217 Anton Skinner said that he understood the police case to have been inconclusive due to lack of corroborative evidence. However, he concluded that WN216 was telling the truth and decided that WN335 had to be removed. WN335 was permitted to take early retirement with an enhanced

[212] WD007092/161
[213] Day 89/19
[214] Day 89/32
[215] Day 89/338
[216] Day 89/30
[217] Day 89/47

pension. Anton Skinner recalled that he had agreed to give WN335 a general reference (not one supporting working with children) and in fact did so, on the basis that "*on the face of it WN335 had been a good employee and had worked well".*[218]

9.218 WN335 said, in evidence to the Inquiry, that he thought an investigation had been conducted by Marnie Baudains which had concluded that he was innocent of the allegations, however he admitted that this was conjecture[219] and the Inquiry has not seen any evidence of such an investigation.

9.219 Anton Skinner wrote a letter to the President of the Education Committee[220] following the decision not to prosecute. He set out matters of "*gross professional misconduct*" on the part of WN335, including:

- Promoting WN216's involvement in a role connected with the Home; allowing him to engage with other vulnerable teenagers and encouraging him to believe that he might develop a career in child care.
- Allowing WN216 to be present at the Home at night, in a position of sole responsibility.
- Placing himself in numerous vulnerable situations with WN216 by giving him a lift home and spending time in his flat alone with him.

9.220 The letter concluded that Anton Skinner considered WN335 to be *"an unacceptable risk professionally in the area of direct work with, or responsibility for, children in the care of the Education Committee"*.[221] In evidence to the Inquiry he said that he told WN335 that unless he resigned he would tell the Education Committee that he no longer had confidence in him.[222]

9.221 Anton Skinner told the Inquiry that although there were disciplinary procedures for Children's Services personnel, they were not used often and were not particularly advanced at that stage. Anton Skinner said that he did

[218] Day 89/57
[219] Day 84/26
[220] WD006632/50
[221] WD006632/52
[222] WS00614/40

not feel that there should be a disciplinary procedure as he wanted WN335 to resign and felt that WN335 could not have arrived at any other conclusion than having to resign or be sacked. He considered that he had expedited matters with a more direct approach but he admitted that the disciplinary procedure would have led to a determination on the facts, which would have been available for future employers.[223]

9.222 WN335's version of events was that it was his decision to resign and leave the island after having acknowledged his error of judgement. He also recalled a discussion about potential other roles, but was told that there were not any available.[224] Despite the contemporaneous note (of considering alternative roles), Anton Skinner stated in evidence that he was very clear to WN335 that he could not continue in employment with Children's Services.[225]

9.223 Anton Skinner said that this was a case which exemplified the frustration of investigating cases with no corroborating evidence. Ultimately, the decision was one made by the Crown Officers and he believes these were made in good faith.[226] In evidence, he spoke of frustrations in child protection proceedings on the basis that they could only obtain convictions where there is an admission (for example, Les Hughes), there is forensic evidence or there is an "*overwhelming preponderance of testimony from a large number of individuals*".[227] We note that this only applies to criminal prosecutions, and not to disciplinary proceedings.

9.224 Following this incident, allegations were subsequently made by Darren Picot that WN335 had also attempted to sexually assault him. In evidence to the Inquiry, WN335 denied these allegations.[228]

9.225 **Findings:** We find that the response to the significant allegations made against WN335 in 1991 was inadequate according to the standards of the time. Despite Anton Skinner accepting that it was not the role of the Social

[223] Day 89/61
[224] Day 84/31 and WD006632/48
[225] Day 89/56
[226] WS000614/41
[227] Day 89/43
[228] Day 84/8

Worker to make a judgement about the veracity of allegations but to listen and explain to the child what was going to happen, in this case he wrote an inappropriate memo setting out his findings, including his views on the truth of the allegations.[229]

9.226 Allegations were referred to the police, in accordance with accepted practice of the time, but only after investigations had already been carried out by Children's Services, which could have been to the detriment of the police investigation and went beyond merely collecting the initial information.

9.227 After concluding that WN335 was an unacceptable risk and had committed gross misconduct, Anton Skinner and the Education Department decided that he should be allowed to resign or retire with a reference, rather than instigating a disciplinary investigation. On the basis of the facts that were established by Anton Skinner, albeit in absence of a properly conducted disciplinary investigation, the decision to provide WN335 with a reference for another job working with vulnerable individuals was inappropriate.

9.228 We note that there were no relevant policies and procedures in place in Jersey at the time. However, multi-agency working had been in place for a number of years at that point, and the "Working Together" guidance had recently been published in England, which set out that disciplinary proceedings must be considered even if there is insufficient evidence for an allegation to be prosecuted.

9.229 We note that this matter is further evidence of a common theme around this period (the late 1980s and early 1990s) in which Children's Services took the easiest route of getting suspected perpetrators to leave their posts, thereby avoiding conflict and the reputational embarrassment that could arise from disciplinary proceedings.

<u>WN166 and another</u>

9.230 In 2001, WN698 made a complaint of physical assault against two staff members, WN166 and a member of staff. The staff members, in turn,

[229] Day 89/47

alleged assault by WN698 during the course of restraint, which was deemed by senior management to have been necessary to secure her safety as she was attempting to abscond.

9.231 Children's Services held a strategy meeting attended by senior staff and the police. Minutes of the meeting record the action taken and the actions to follow. It was decided that the restraint used was reasonable and that the two staff members should remain working at Heathfield, while noting "*Police to notify immediately should further information suggests any use of unreasonable force*".[230]

9.232 **Finding:** Children's Services responded appropriately to an allegation that a restraint had amounted to assault, by holding a strategy meeting in response to the allegations, which was attended by police. When the police decided not to take any action, it was noted that they should be told if any further information suggested any unreasonable use of force. This was an adequate response according to the standards of the time.

<u>WN820</u>

9.233 In August 2006, a 15-year-old female resident at Heathfield ran away with a friend and told the friend that she was doing so because WN820 (a member of staff at the Home) told her would sanction her if she did not give him "*a blow job".* The friend reported this to other children and to a staff member. The staff member met with the complainant, who told him it was true. Her key worker asked her whether she wanted to: (i) do something, or (ii) do nothing. It was explained that if the latter, nothing would happen as she would not be regarded as having made a complaint. She said that she wanted something to be done and that she wanted to talk to the police. The SOJP's FPT were informed, as were Phil Dennett and Joe Kennedy.[231] A

[230] WD006831
[231] WD009050

strategy discussion was held over the telephone[232] between the relevant key worker and DI Alison Fossey of the FPT.[233]

9.234 During a video interview, the complainant told the police that WN820 forced her to give him a blow job on one occasion and had recently asked her to put a certain skirt on.[234]

9.235 WN820 was made aware of the allegation by a fellow staff member. He took advice from his Manager, Simon Bellwood, and wrote a statement outlining his actions. He denied the allegation.[235] It was explained to him in an early meeting that he must not make contact with the complainant, or any of the other young people resident in any of the children's homes, until informed otherwise.[236]

9.236 WN820 was arrested and interviewed by the police. He gave a '*no comment*' interview, other than some general background about his role.[237] He was suspended from work three days later, on the basis that the investigation was ongoing and looked as though it would go on for some considerable time.[238] Following a police investigation, initial advice was provided in August that there was no realistic prospect of conviction, and a final decision not to prosecute was taken in December 2006.

9.237 In January 2007, a return-to-work meeting was held by Kevin Parr-Burman, Manager of Heathfield at the time.[239] During this meeting, WN820 said that on the night about which the allegations had been made, he had gone into the complainant's bedroom and saw that she was showing him her thong. He then closed the door and only went back in when she was properly covered. He accepted that in the future he would always have someone with him when checking on residents at night.[240]

[232] According to the records, urgent casework commitments within the Family Protection Team meant that they were unable to hold a strategy meeting in person
[233] WD009053
[234] WD006877
[235] WD006877
[236] WD009049
[237] WD006878
[238] WD009051/53–54
[239] WD009051/52
[240] WD009051/52

9.238 In October 2007, an anonymous letter was received expressing concerns that WN820 had returned to work "*with no questions asked*". A report from Marnie Baudains[241] later that month made the following comment:

> *"It is understood that, during the investigation, the complainant refused to make a statement either confirming or denying the allegation, although her confidante made a statement saying that the complainant had confessed to her that she had made the story up. The police investigation concluded that there was no case to answer and [WN820] returned to his duties."*

9.239 Marnie Baudains concluded in her report that an appropriate procedure was followed and WN820's return to Heathfield was appropriate in the light of the outcome of the investigation.

9.240 During a supervision session in November 2007,[242] by which time WN820 had moved to Greenfields, he was adamant that he was a victim of a false complaint and said that the complainant had divulged information to one of her friends that the allegation was false. He felt let down by Heathfield and did not think he received any support from management, nor how isolated he would feel during the suspension process.

9.241 Phil Dennett, in his evidence to the Inquiry,[243] said that due consideration was given to the return of WN820 to work. He was required to change his practices and was supervised, as he had put himself in an inappropriate position by entering a young person's bedroom accompanied. When asked about the decision not to instigate disciplinary proceedings, Phil Dennett said that there would have been a discussion, within the senior management team, with Social Services, with the police and with their own HR Department.[244]

9.242 **Findings:** The initial response to this disclosure of abuse was in accordance with the policies and procedures of the day – which at that stage were the 2005 Jersey Child Protection Procedures.

[241] WD008988
[242] WD009048
[243] WS000708/5
[244] Day 134/50

9.243 However, following the decision not to prosecute the case, there was no disciplinary investigation. Phil Dennett said that there would have been a discussion before deciding not to instigate disciplinary proceedings, but the Inquiry has not seen any evidence of such a discussion. The relevant procedures state that "*The fact that a prosecution doesn't follow does not mean that action in relation to … employee discipline is not necessary".* In our view, this was an inexplicable failure of the HSSD to follow their own policies and procedures.

9.244 Following a complaint about the handling of the case a few months after WN820 returned to work, Marnie Baudains stated that the complainant refused to make a statement and her confidante had made a statement confessing that the story was made up. As set out above, the complainant did in fact make a statement to the police[245] (via a video interview) and the Inquiry has not received any statement from the confidante stating that the complainant had admitted making the story up. Marnie Baudains set out that following the police investigation, WN820 returned to his duties. She did not investigate why there had been no thought given to a disciplinary investigation. Again, we consider this to have been an inadequate response to a complaint relating to the handling of an allegation of abuse.

Kevin Parr-Burman

9.245 In June 2008, an allegation was made that the Manager of Heathfield, Kevin Parr-Burman, used excessive force in taking hold of a vulnerable resident, WN823.[246] The allegation was reported by two staff members on duty at the time to their manager. It was passed to the SOJP's PPU to investigate.

9.246 The two staff members set out the allegation to the police. One member felt uncomfortable continuing to hold onto WN823, who was visibly distressed. The staff member let go as he felt that Kevin Parr-Burman was *"becoming out of contro*l". The other staff member, in her statement dated 21 June 2008, said that she thought that Kevin Parr-Burman's actions were

[245] WD006877/3
[246] WD006059

inappropriate and the force used was unnecessary.[247] However, in the SOJP report summarising this member of staff's evidence[248] and in the advices on charge written by Robin Morris[249] and John Edmonds,[250] they quote what appears to be a different statement, in which the member of staff apparently says: "*I also have to say that there was no excessive use of physical force but the use of a physical approach was in these circumstances, in my opinion, probably disproportionate to the circumstances."* The Inquiry does not have a copy of this statement.

9.247 Kevin Parr-Burman was interviewed by the police in July 2008. He said[251] that Heathfield was an inappropriate placement for WN823 but he accepted that they had to do their best for him. He did not disagree that it was inappropriate to take hold of the back of WN23's T-shirt and try to pull him downstairs. He did not think that he "*lost it*" with WN823 but acknowledged that he was less patient than he would normally have been. He acknowledged "*that in retrospect* [the incident] *was inappropriate*" but said that it was not a deliberate act to injure a young person; it was not an assault. He accepted that he acted unreasonably but did not think he had gone beyond reasonable force.

9.248 The SOJP noted that Kevin Parr-Burman was very experienced in working with young people presenting with challenging behaviour, and was trained in child protection issues and skilled in crisis intervention.[252]

9.249 In September 2008, an email from Steve McVay put forward that view that Kevin Parr-Burman had acted inappropriately and regardless of the police outcome, should be dealt with internally in some way.[253] A report from Joe Kennedy suggested moving Kevin Parr-Burman to a management role at La Preference (which was what eventually happened) or a role at the White

[247] WD006060
[248] WD006059/3
[249] WD006849/11
[250] WD006849/6
[251] WD006062
[252] WD006059
[253] WD009044

House. He noted that "*there is a likelihood that the police will not proceed which will instigate an internal inquiry".*[254]

9.250 Following the police investigation, the decision on whether or not he should be prosecuted was taken by John Edmonds of the Law Officers' Department (LOD). He decided that *"this is not a case where there is a realistic prospect of conviction and the Children's Service should be advised to deal with the conduct of Mr Parr-Burman through their own internal disciplinary process".*[255]

9.251 This determination followed the view of the AG that *"criminal proceedings are not at all appropriate*" but that "*Mr Parr-Burman acted in a way in which he should not have done*" and it was a matter for internal disciplinary procedures.[256]

9.252 John Edmonds also noted that Kevin Parr-Burman had acted inappropriately and had not handled the situation well. These were matters in respect of which he said the Children's Service needed to consider giving formal advice and/or training. He also noted that there may have been aspects of the case that technically amounted to an assault.

9.253 A meeting was held shortly thereafter to assess risk in relation to Kevin Parr-Burman's return to work. Risk assessment information was provided by Phil Dennett and Joe Kennedy. The Panel (Richard Jouault, Marnie Baudains and Rose Naylor) made the decision that a formal disciplinary procedure was not necessary as this was the first instance of the employee failing to meet the expected standards of conduct and it did not constitute serious or gross misconduct. The Panel decided that Kevin Parr-Burman should return to work at Heathfield subject to receiving proper supervision, monitoring and, if appropriate, training from Joe Kennedy.

9.254 In evidence to the Inquiry Phil Dennett was shown the relevant Civil Service disciplinary procedure[257] on gross misconduct, serious misconduct, assault

[254] WD009047
[255] WD006849/2
[256] WD006849/3
[257] Set out in the table above

and negligence. He said that in his opinion the matter should have been referred to a disciplinary panel. As set out above, Kevin Parr-Burman did in fact move across to the role of Manager at La Preference. In 2010, Kevin Parr-Burman confirmed that there had been no work-related updating or training following his return to work.

9.255 **Findings:** The disclosure by members of staff was appropriately passed to senior management and to the police. Following an investigation and a decision not to prosecute, the HSSD convened a meeting to assess risk and decide whether to implement the formal disciplinary procedure. This was all in accordance with the Child Protection Guidelines at the time.

9.256 It is surprising that no formal disciplinary procedure was implemented given the views expressed by the LOD and the admissions by Kevin Parr-Burman. The matter should have been referred to a disciplinary panel.

9.257 We are also concerned that despite the recommendations that Kevin Parr-Burman return to work subject to proper supervision, monitoring and training, in 2010 he stated that he never received any such training.

<u>WN819</u>

9.258 In May 2000, a resident at Heathfield alleged that he had been assaulted by WN819. When interviewed by the police, WN819 admitted involvement in altercations with the complainant and his brother, but said that he did not assault them. His contemporaneous note was that the child had banged his head on the door on purpose.[258] The police report concluded that there was insufficient evidence to prosecute WN819.[259]

9.259 Following this decision, an internal investigation by Children's Services concluded that WN819 was being targeted and threatened. There was concern that further allegations would be made.[260] Phil Dennett noted concern about the physical restraint techniques used, particularly the use of a duvet. He said that this highlighted the need for effective care and control

[258] WD006093/311
[259] WD006093/313
[260] WD006092/296

training which was to be provided in the summer and was to include WN819.[261]

9.260 In January 2009, a different resident at Heathfield alleged that WN819 had assaulted him. This was investigated by the SOJP. One staff member saw the incident and said that the staff had some training in restraint of children and that the way WN819 was holding the child was inappropriate.[262] Another worker told the police that he heard the resident shouting at WN819 following the incident. The complainant then told him what happened, and said that he wanted to make a complaint. The care worker spoke to WN819 who told him: "*I snapped but you need to understand he was winding them all up".* He completed a critical incident report.[263]

9.261 WN819 was interviewed by the police and said that he was an unqualified but experienced care worker who had training in restraint of children. The police doctor who examined the complainant noted: *" … this area of the neck is not a common area to be injured accidentally*". A decision was eventually made in March 2010 that although the offence of common assault may be made out, there should be no prosecution but that any issues arising should be dealt with through internal disciplinary channels.[264] During the period in which this decision was being made, the complainant's Social Worker had expressed the opinion that it would not be in his best interests for a prosecution to be undertaken and that an investigation by Social Services was taking place with internal disciplinary proceedings to follow.[265] The Social Worker subsequently confirmed that the complainant did want to go to court and at no time had she ever stated that he could not give evidence.[266]

9.262 Following the decision not to prosecute, an internal investigation report was completed in April 2010 by the Acting Manager of Heathfield.[267] WN819, staff, and other residents were interviewed, but the complainant failed to

[261] WD006092/293
[262] WD006894
[263] WD006888
[264] WD006896
[265] WD007918/6
[266] WD007918/9
[267] WD009173

attend appointments for interview. The report concluded[268] that there should be no formal disciplinary proceedings, but said that the situation could have been avoided if WN819 had implemented TCI; he was not in control of the situation and this had led to him restraining the complainant in an untrained and unprofessional manner. It was *"essential"* that WN819 was given adequate support and supervision. He was required to retrain on a TCI course and receive weekly supervision for three months. It was essential that staff received debriefs following serious incidents.

9.263 In evidence to the Inquiry,[269] Phil Dennett said that the decision not to instigate disciplinary proceedings was a difficult area, and he would not have been surprised if it had gone either way.

9.264 **Findings:** On the basis of the evidence before the Inquiry, the response to the allegation of assault in 2000 was adequate. An internal investigation was conducted following the police's decision to take no further action, which identified concerns and highlighted training needs.

9.265 In our view, the response by the HSSD to the 2009 allegation of physical assault was initially adequate. There was a multi-agency response and following the decision not to prosecute, an internal investigation report was carried out. This was in accordance with the Department's own policies and procedures.

9.266 However, this is another occasion on which it is surprising that no formal disciplinary proceedings were instigated, given the conclusion that WN819 had restrained the complainant in an "*untrained and unprofessional manner*". The recommendations for proper support, supervision and retraining were appropriate.

[268] WD009173/15
[269] Day 134/101

La Preference: Voluntary Home (1951–1984)

WN729

9.267 In response to the allegations made against her and other staff, WN729 gave the following evidence:[270]

- Regarding Edward Walton's allegation that a member of staff slammed their fist onto a child's head before punching/kicking the child's stomach, WN729 said that she never witnessed such behaviour. It was implausible as there would have been enough staff around to know about it.
- She never saw a child struck on the head with a ladle. Children were encouraged to eat their food but were not forced to do so.
- She never caned a child and children did not regularly abscond. She did smack the bottoms of some of the younger children; this was not recorded anywhere. Older children might be prevented from attending the youth club for a period of time.
- She did not think that any child was hit with a belt, but did not know what happened "*behind closed doors*". She believed that bruising or bleeding would have been noticed by another staff member.
- She did not slap WN45 on the face while she slept.
- She had no recollection of being told by WN45 that she was being abused by Roger Horobin. In response to WN45's allegation that WN729 forced her to go out on a trip with Roger Horobin, WN729 said that the CCOs were responsible for deciding upon visits for children at La Preference. WN729 was advised when a child came to La Preference as to who should see them and who should not. She would not force a child to go out with anybody if they did not want to do so.[271]

9.268 We note that despite WN729's failure to recall this disclosure, there is contemporaneous evidence[272] that records that, upon receipt of these disclosures, she immediately reported the incident to Charles Smith, who

[270] WS000627; Day 95
[271] Day 95/162
[272] WD007346/14

informed the police. The subsequent investigations led to Roger Horobin's conviction in 1979.

9.269 **Finding:** In our view, such a report was an adequate response according to the standards of the time, when there were no relevant policies and procedures in place.

WN7

9.270 In 2003, WN617 made allegations that he had been assaulted by WN7 at La Preference in the early 1980s, when the Home was run by Christine Wilson. Following the reporting of this to Children's Services, an internal investigation was undertaken by John Cox (Service Manager of Adult Social Work) including interviews with WN617 and members of staff. WN617 had initially called the SOJP's CPU. They referred him to Marnie Baudains of Children's Services.

9.271 A record of an interview conducted with Christine Wilson notes that she said[273] that WN7 did not work at La Preference while she was there, and it was unlikely he would have had reason to visit. If he had visited, it was very unlikely that he would have been unaccompanied. She said that WN617 was pleasant but occasionally "*exploded*" and would have "*screamed blue murder*" if anything like that had occurred.

9.272 WN7 was also interviewed and said that[274] he had no real recollection of WN617 and no recollection of the allegation described. He thought it was the kind of thing he would not forget. At the time of the allegation he would not normally visit children's homes, although may have visited La Preference on occasion.

9.273 John Cox sent a letter to WN617 in June 2003 setting out his findings:[275]

- There was no "*collaborative*" [sic] evidence to support the complaint.

[273] WD003846
[274] WD003849
[275] WD003845

- The factual evidence confirmed that WN7 never worked at La Preference and was not involved in a residential care role at that time.
- The available evidence indicated that it was unlikely that WN7 visited La Preference but that, if he had, he would have been accompanied.

9.274 WN688 (staff member at St Mark's Adolescent Centre) recalled that in 1990, WN617 came to him and told him that WN7 used to hit him. When asked if he wanted this reported, WN617 said "*What is the point?*". More recently when they discussed the matter again, WN688 suggested that WN617 write to Marnie Baudains on the basis that "*different staff had different ideas now and those things were not tolerated now*".[276]

9.275 **Finding:** The response to the 2003 disclosure of an assault having taken place in the early 1980s appears to have been adequate according to the standard of the time. The disclosure was initially made to the SOJP, and was then passed on to Children's Services. An internal investigation was carried out by an individual outside of the relevant department.

La Preference: States run (1984–2012)

Miscellaneous

9.276 As noted above, in December 1996, a file note[277] suggests that a child (by then a resident at La Preference) made disclosures to Fay Buesnel that she had been sexually abused by an associate of her mother's a few months before. This information was then passed to Marnie Baudains and then on to Selina Larkin to assess whether the child needed further protection. When Selina Larkin tried to investigate, she was told that the child had gone home overnight as Fay Buesnel did not feel that she was in any danger at home, even though the alleged perpetrator was at the house "*most of the time*".

9.277 The matter was discussed at a CPT meeting but nothing was done immediately. A file note three weeks later records a meeting between Ms Larkin, a member of staff at La Preference, the child, and the child's mother.

[276] WD003532
[277] WD008625

The mother assured them that the child would be safe if she returned home.[278]

9.278 In January 1997, a note records that the CPT had investigated and there would be no further action on their part.[279] In March 1997, the child made a further disclosure about the sexual abuse to her boyfriend, which was passed to Richard Davenport. He noted: "*I think we will find that … It has been dealt with by CPT.*"[280] This does not appear to have been pursued any further at this time.

9.279 In 2011, the alleged perpetrator was charged with three counts of indecent assault and one count of rape over a period of 24 years, including the allegation first raised in 1996. In March 2012, he was convicted of rape and indecent assault; the 1996 allegation was not pursued.

9.280 **Finding:** The allegation was appropriately reported to senior management and dealt with by the multi-agency CPT. In our view, it was not appropriate for the child to be returned home before an assessment had been made as to whether she needed further protection. The subsequent decision of the CPT to take no further action is not one that we can assess on the basis of the evidence.

<u>Ernest Mallet</u>

9.281 Ernest Mallet said that his response to bad behaviour was to shout.[281] He also recalled having to restrain children occasionally despite not receiving any restraint training until 2000.[282]

9.282 In evidence to the Inquiry, he referred to an occasion in 1992 when a father complained that Ernest Mallet on several occasions physically assaulted a child in care at La Preference.[283] Ernest Mallet denied most of the allegations but did admit smacking the child and making him stand in the corridor to cool down after finding him messing about in the girls'

[278] WD008626
[279] WD008592/7
[280] WD008593
[281] Day 81/182
[282] WS000602/21
[283] WD006573/15

bedrooms.[284] At a disciplinary hearing he acknowledged that the smacking was "*unacceptable and in contravention of departmental policy*"; he was given a first and final warning.[285] Around the time of this investigation, staff at La Preference were advised about the need to take extra care in respect of touching or hitting children and to refrain from shouting at them.[286]

9.283 In 2000, a further complaint was made that Ernest Mallet assaulted a child, by restraining him by the throat. As noted above, following disclosure by the child, WN687 quickly passed the information to Phil Dennett (the Manager of the Children's Service), and a swift action plan was carried out. Phil Dennett conducted an investigation, during which time Ernest Mallet was not suspended but was told that he should stay at home. He and the two children involved were interviewed and prepared statements.[287] In his report on the matter, Phil Dennett highlighted various areas of concern, including the inappropriate restraint by Ernest Mallett, the lack of staff training, and the inadequate recording of the incident. Phil Dennett made several recommendations, including supervision for Ernest Mallett (who would return to work soon), a review of internal reporting systems, and care and control training for all staff.[288] This was provided later in 2000 but did not cover de-escalation.[289]

9.284 A meeting was held with Ernest Mallet following receipt of the report. It was noted that no formal disciplinary action was to be taken but a note placed on his file.[290] Ernest Mallet told the Inquiry that he felt that he had a lack of support from his Manager at that time.[291]

9.285 **Findings:** In both 1992 and 2000, investigations were carried out following allegations of physical abuse at La Preference. The response to the first allegation was adequate according to the standards of the time – disciplinary

[284] WS000602/21
[285] WD006573/25
[286] WD006573/28
[287] Day 81/180
[288] WD006573/30–31
[289] Day 81/199
[290] WD006573/42
[291] Day 81

proceedings were carried out leading to a final warning, and staff were advised to take extra care with children and refrain from shouting at them.

9.286 We think that the broad response to the complaint in 2000 was adequate, with a reasonable investigation and helpful recommendations made by Phil Dennett. However, given that he found that Ernest Mallett restrained the child by the neck, we think it was inappropriate that no formal disciplinary proceedings were instigated.

9.287 Furthermore, in neither case does there appear to have been any multi-agency involvement in the investigation, despite the allegations including assaults that should have warranted investigation by the police. In both cases, this was inadequate.

WN7

9.288 In March 2004, allegations were made separately by WN749 and WN618 that WN7 had physically assaulted them at La Preference. WN749's allegations related to an incident in January 2004. WN618's allegation related to an incident in 2002

9.289 Children's Services' response to these allegations is noted in a document[292] which sets out the action taken between the 27 February 2004 and 11 March 2004. The author of the report is unknown.

9.290 Following disclosure by WN749 to Anne Shine (CCO), Anne Shine completed a report and discussed the options available her; a formal complaint to the SOJP, a formal complaint to Children's Services, or an informal complaint to Children's Services. WN749 confirmed that she wished to make a complaint to the police.

9.291 Children's Services senior managers agreed that WN7 would be told about the investigation and arrangements made to restrict his duties in relation to La Preference. The SOJP were advised of this plan. Allegations later made

[292] WD009342

by WN619 to staff at Heathfield about having witnessed WN7 assaulting WN618 were also to be considered as part of the ongoing investigation.

9.292 WN718, a member of staff, gave a statement to the SOJP about the allegation,[293] stating that the staff were trained in control and restraint but what she saw WN7 doing was "*not part of the training programme given to staff*". However, she said that in her view, WN7 "*was using reasonable force*".

9.293 In May 2004, WN687 gave a statement to the SOJP.[294] He said that a "Crisis Intervention Package" called TCI had been introduced into Children's Services in 2001 – leading to over 150 residential child care workers being trained. Its use was not optional, and physical restraint would only be used if professionally indicated and "*if the young person, other clients, staff members or others are at imminent risk of physical harm".*

9.294 WN7 was interviewed by the SOJP in June 2004.[295] In relation to the allegations made by WN749 he said at the time that he used the "*minimum amount of force needed to control the situation*". He said that he pushed her on the shoulder at arm's length and did not pull her hair, and that he did not slap her leg but did touch it to remove it from the furniture.

9.295 In relation to the allegations made by WN618, WN7 told the SOJP that he could not recall the incident as alleged, and that if he had picked WN618 up, he certainly would not have thrown him anywhere.

9.296 In a police report in July 2004, DC Gregory concluded that there was insufficient evidence to prosecute WN7.[296] However he also noted a number of discrepancies in WN7's account.[297] For example, WN7 said at one point that he remembered the incident very clearly because "*the touching of a child is a serious thing*" and then at various other points in interview stated he could not recall the incident clearly, and later stated that the incident was "*nothing more than what happens a thousand times a day within a children's*

[293] WD004888
[294] WD004889
[295] WD005353; WD005354
[296] WD004886
[297] WD005353; WD005354

home". Furthermore, WN7 said he spoke to a Manager, Phil Dennett, about the incident with WN749, because "*whenever I touch someone of any nature I record it*". However, he did not record it in writing, explaining that he did not think it was serious enough. Phil Dennett did not mention this in his statement (in 2004) and in that statement, said that he recalled no issues in the unit on the day in question. Finally, WN7 stated he was using prescribed methods of "redirection" and "proximity control". However, the TCI training manual does not provide for physical intervention in the context of "redirection" or "proximity control".

9.297 In evidence to the Inquiry, WN7 said that WN749's allegations were untrue and he did not use any violence but used a recognised method of restraint (TCI).[298] He recalled that there was no internal investigation following the decision not to prosecute.[299]

9.298 A memo from the Police Legal Adviser dated August 2004 noted:

> *" … it is clear from [WN7]'s interview and the observations of [WN718] that the guidance offered in the TCI manual was not being followed. It cannot be said that operating outside these guidelines would amount to a criminal offence, nevertheless it will cause the Department concern that one of their trainers in this area appears to have breached the guidelines".*[300]

9.299 In September 2004, DI Underwood met with Phil Dennett. A file note records that he explained that this was not a case for prosecution but that there must be "*genuine concerns regarding the manner and actions of a member of staff who is a Therapeutic Crisis Intervention Trainer. Operating outside those guidelines laid down by the Social Services must be a breach of internal policy and procedures*".[301]

9.300 When asked about this in evidence to the Inquiry, Phil Dennett thought he had had a discussion with WN7 and that following the incident they introduced an analysis of incidents whereby an external reviewer was

[298] Day 66
[299] WD008410
[300] WD008410
[301] WD005348

brought in.[302] On the second occasion he gave evidence to the Inquiry,[303] he explained that he did not have managerial responsibility for WN7 from this time as WN7 was not employed within a residential care home and was therefore working within Social Services rather than the Children's Executive. Thus, it was not appropriate for him to lead any disciplinary process.

9.301 The Inquiry has not seen any evidence of disciplinary action being taken. Phil Dennett's view was that *"there should have been a disciplinary, or a pre-disciplinary look at it which would have ascertained what would have happened, why it happened, given the TCI trainer that this person was"*.[304]

9.302 **Findings:** We find that the initial handling of the disclosures of physical abuse was adequate – the children were consulted and the matter was passed on to the SOJP appropriately.

9.303 However, following the decision that there would be no prosecution, the response was inadequate. It would have been accepted practice at that time that just because there may be insufficient evidence to support a prosecution, it does not mean that disciplinary procedures should not be pursued. Such a course of action was suggested by the Police Legal Adviser and by DI Underwood in his meeting with Phil Dennett. No disciplinary procedures were initiated and this was inadequate.

<u>WN662</u>

9.304 In response to the allegations made against him, WN662 gave evidence to the Inquiry,[305] in addition to the evidence he gave in August 2009 to the SOJP.[306] In response to the allegations that he smacked or pushed a child in 1994/95 he could not recall the incident, but may have gently pushed the child and did not think that that action was inappropriate. The staff member who reported the incident did not raise it with him at the time. It was reported

[302] Day 95 – the first occasion on which he gave evidence to the Inquiry
[303] Day 134/231
[304] Day 134/32
[305] WS000607; Day 83/29
[306] WD00691/4

by the staff member contemporaneously[307] but he did not recall being spoken to and could not recall the details. No formal action was taken.

9.305 WN662 denied the allegations made by a former resident at La Preference that he beat him with a bat, chased him, covered him with a tarpaulin, sprayed him with water and then threw a wet blanket over him. He said that no such events took place. He also denied the allegations made by WN663 that he kicked him when WN663 was making noise in the sandpit and pushed another child's face into the sandpit while battering him with his fists. WN662 also denied WN663's allegation that he smacked a girl on the bare bottom after she wet herself. He explained that such issues were dealt with by female members of staff and that other staff would have seen any such incident happening.

9.306 In response to the allegation that he put his hand down a child's trousers he emphatically denied it, saying that he never sexually assaulted any of the children in his care. Furthermore, he denied the allegations that he pulled a child out of bed by the ear and forced a child to stand in the corner of the bedroom for a long time, dressed only in underpants. This allegation was made by a member of staff, WN718.[308]

9.307 In response to William Dubois' allegation that he would beat anyone in the Home (La Preference) and pick on the most vulnerable children, WN662 said that he never hit anybody. He said that if he had done so there would have been a mark and somebody would have noticed. He denied the allegation that he was a bully and made the children do tasks like picking up all the leaves in the garden and then tipping them out before asking the children to repeat the exercise.

WN753

9.308 In August 2006, WN752 (a 17-year-old former resident of Heathfield) disclosed to a member of the Leaving Care Team, Grace Little, that she had

[307] WD006224
[308] WD006225

engaged in a sexual relationship with WN753, (a member of staff at La Preference and her former key worker).

9.309 A background document[309] notes that following the disclosure, Grace Little provided advice and support for WN752 and reported the disclosure the same day to Danny Wherry. Tony Le Sueur and DI Alison Fossey of the SOJP were also informed. WN753 was on holiday in France at the time with staff and residents from La Preference, and his removal from the group was immediately ordered. He was to have no contact with them. A strategy meeting held the following day agreed that WN753 be suspended and that DI Alison Fossey would seek advice as to whether a criminal offence had been committed. It was subsequently confirmed that no offence had been committed.[310]

9.310 The meeting concluded that if WN753 admitted the facts, the best outcome was to request his resignation in writing along with the reason why. The police and HR would then have it on record if WN753 attempted to work with children in Jersey again.

9.311 A disciplinary meeting was held the next day[311] and WN753 admitted the sexual relationship with WN752. He was advised that it was an act of gross misconduct and that his position was untenable. His letter of resignation has not been seen by the Inquiry and does not appear to have remained on his file, however an extract is included in the background note,[312] as follows:

> *"I (WN753) have been made aware that (the young woman) has disclosed that she is pregnant with my child. I accept that it is likely and admit to having sexual relations with her. I further accept that this is an act of gross misconduct. In view of the above I hereby tender my resignation effective immediately."*

9.312 A note "summary of findings" prepared by Phil Dennett was obtained by the Inquiry[313] and sets out the facts of the investigation, as noted above. It also acknowledged that WN752 was still a "child in care" up to the age of 18 and

[309] WD006395
[310] Although we note that it would have been so from January 2007, when the Sexual Offences (Jersey) Law 2007 was adopted – as seen at WD009041
[311] WD004896
[312] WD006395
[313] WD009041

that WN753's resignation was accepted although an investigation into "gross misconduct" would have taken place if that had not been the case. It was noted that there was no evidence that any further young people were at risk from WN753, but described his actions as "*extremely inappropriate*" and noted that it may have led to a prosecution if the situation had arisen a few months later. The note concludes that it should be placed on record that WN753 "*should not be considered appropriate for future work with young people in Jersey and that the point should be made in any future requests for references from potential employers".*

9.313 In his first statement to the Inquiry, Phil Dennett said that *"the advice we received from the HR Department was that we could not dismiss* [WN753] *as he was not in breach of contract because the girl was no longer in our care"*.[314] In his second statement to the Inquiry, Phil Dennett added that they had no proper HR support at all. They were told that if they tried to discipline WN753 they would be unsuccessful and would have to allow him to remain in post. He described the situation as *"probably the most frustrated I found myself during my career in child care"*. He went on to say: "*in my opinion this member of staff should have been dismissed. I am satisfied that this would be dealt with differently now should a similar situation arise following the introduction of 'abuse of trust' legislation".*[315]

9.314 Phil Dennett added that now the General Social Care Council (GSCC) would be informed, but this system was not in place at that time for non-qualified social workers.[316] He said that WN753's actions amounted to gross misconduct according to the Civil Service disciplinary procedures[317] and that he did not believe the approach followed had anything to do with any unwelcome attention or publicity that the disciplinary process might involve.[318]

9.315 **Finding:** This matter was not handled in accordance with the policy and procedure in place at the time. In evidence to the Inquiry, Phil Dennett said

[314] WS000628/43
[315] WS000708/8
[316] Day 134/57
[317] Day 134/57
[318] Day 134/59

that the advice from HR was that WN753 was not in breach of contract "*because the girl was no longer in our care*". However, Phil Dennett's contemporaneous note clearly stated that WN752 was a child in care until the age of 18. The Panel regards the response from HR as wholly unsatisfactory, for which the HSSD is responsible. Regardless of the age or status of WN752 when the matter came to light, WN753 had been guilty of gross misconduct and had admitted as much. Given that legislation was enacted only a few months later that would have criminalised WN753's conduct, it is clear that it was regarded as unacceptable. Disciplinary proceedings should have been instituted rather than allowing the matter to end with resignation.

Kevin Parr-Burman

9.316 In August 2010, a resident at La Preference alleged that he had been assaulted by Kevin Parr-Burman, the Manager of the Home. Kevin Parr-Burman had previously been the subject of allegations of assault against a child in care at Heathfield in 2008, following which he was moved to La Preference.

9.317 The SOJP investigated the 2010 allegation and interviewed Kevin Parr-Burman.[319] He said that he did not assault the child or restrain him in any way but merely put his hand lightly on the child's shoulder to guide him off the pool table. He accepted that he did not record anything in the report running log or mention the incident to other staff on duty. He admitted that in hindsight he should have done so. Other staff members were questioned by the SOJP but none witnessed the incident.

9.318 Following the SOJP investigation, the matter was passed to the LOD. The decision was taken not to proceed to prosecution. In December 2010, the AG noted his concern that Kevin Parr-Burman "*used force beyond what was needed and that he had not recorded such a significant event in the daily logs*". He recommended that "*the Children's Service deal with this through internal disciplinary procedures and training*". The Children's Service agreed

[319] WD006884

to do "*an internal investigation of the incident. Part of this investigation will look at whether Mr Parr-Burman will return to La Preference*". [320]

9.319 A meeting held in February 2011 noted that the GSCC had been informed about the allegations against Kevin Parr-Burman and that they would conduct their own investigation.[321]

9.320 In April/May 2011, a management investigation under the disciplinary procedure was carried out.[322] Kevin Parr-Burman was interviewed and said in response to the allegations that he put his hand on the child's shoulder to remove him from the pool table; it was all over in a matter of seconds. He thought that it was wrong that the report was made directly to the police by Ms Larbalestier (a member of staff) without prior discussion with her Line Manager.

9.321 He stated that after the previous allegation (in 2008 at Heathfield) there had been no work-related updating or training provided.

9.322 Kevin Parr-Burman thought it significant that he had not been suspended or put on "gardening leave" even though there were child protection issues. He also said that a child protection conference should have been arranged if there were serious child protection concerns.

9.323 The management investigation also included interviews with various staff members, including Phil Dennett. He described the issue around physical restraint as "*a very real problem for the island in the context of historical abuse investigation. However, there is clear policy for all staff in this area*". He noted that a previous complaint about Kevin Parr-Burman led to the implementation of a supervision and training programme, and that supervision was now in place through Joe Kennedy. The matter had been referred to the GSSC.[323]

[320] WD009060
[321] WD009176 – although the Inquiry has not seen a copy of any referral, nor any response from the GSCC.
[322] WD009056
[323] WD009057

9.324 The management investigation concluded that:[324]

- the matter should not be addressed under the formal disciplinary procedure;
- written guidance should be provided on record-keeping to ensure that incidents were recorded;
- arrangements for clinical supervision should be reviewed in order to support professionals.

9.325 Joe Kennedy subsequently provided a reference for Kevin Parr-Burman.[325] He answered a question as to whether any allegations or concerns had been raised by saying "*there have been no allegations made against Kevin which have resulted in disciplinary sanctions*". Phil Dennett told the Inquiry that Joe Kennedy had spoken to the prospective employer (Dorset County Council) on the telephone about some of the issues concerning Kevin Parr-Burman.[326]

9.326 We note that in February 2013, while working as a Residential Manager in a Children's Home in Cambridgeshire, Kevin Parr-Burman was cautioned for common assault by "*beating a service user*" for inappropriate restraint of a child. In November 2013, the Health and Care Professions Council (HCPC)[327] determined that Kevin Parr-Burman's fitness to practice was impaired and he was suspended. The HCPC noted the following that is relevant to his time in Jersey:[328]

- Kevin Parr-Burman "may not have had recent practical experience of managing challenging behaviour despite his years of experience in the residential field". He had not received Reinforce, Appropriate, Implode, Disruptive (RAID) training on physical intervention and "his lack of appropriate restraint and de-escalation training" was considered a mitigating factor.
- His *"lengthy and apparently satisfactory service"* was noted together with the fact that he had *"no prior HCPC disciplinary matters"*.

[324] WD009056/7
[325] WD009178/88
[326] Day 134/83
[327] The successor to the GSCC
[328] WD008284

9.327 Kevin Parr-Burman's suspension was revoked by the HCPC the following year on the basis that he *"no longer posed a threat to service users"* and it would enable *"a highly experienced and competent social worker to return to social work when he feels confident to do so"*.[329]

9.328 **Findings:** The response to this allegation of abuse by the HSSD was initially in accordance with the policies and procedures of the day. The disclosure was passed to the SOJP and following their investigation and a decision by the LOD, a management investigation was carried out by Children's Services.

9.329 However, given the AG's concern that Kevin Parr-Burman had used "*force beyond what was needed",* we are surprised that no disciplinary proceedings were instigated. Furthermore, we consider that it was inadequate and not in accordance with the policies and procedures of the day that Kevin Parr-Burman was neither suspended nor put on "gardening leave", and that no child protection conference was carried out.

Family Group Home run by WN279 and WN281

9.330 There is conflicting evidence in relation to allegations of abuse at this FGH. Four former residents (WN45, WN319, and WN318, and WN214) made allegations of regular physical and emotional abuse. The complainants describe a regime of cruelty, with regular beatings and casual violence. There are numerous allegations of the foster children being lined up for physical punishment with either WN279 or WN281 smacking the children or hitting them with a plastic cricket bat or a belt.

9.331 Other former residents described a normal, functional household. The natural children of WN279 and WN281 refute the allegations and there is no suggestion that they were involved.

[329] WD008285

Allegations raised in 1975

9.332 In February 1975, one of the residents at the FGH reported to their teacher that they had been physically assaulted by WN279. The CCO, Ms Hogan recorded on 20 February 1975:[330]

> *"Received a message from Saint Luke's School that [WN319] was bruised on his head and said that [WN279] had hit him. Mr Shepherd reported that it was a large, fading bruise on the left temple that [WN319] told him was done at the weekend."*

9.333 The CCO visited the school and spoke to Mr Shepherd who told her that none of the FGH children "*ever really seemed happy*". Mr Shepherd thought [WN214] in particular was given a lot of chores to do at the Home and said "*he in fact used the word drudge*".

9.334 Ms Hogan spoke to WN319 on his own and recorded "*he willingly told me that mummy had hit him".* She saw a slightly yellowing bruise at the corner of his left eye and he said it happened at the weekend when he was in the bathroom. He could not find his wash bag and this was why mummy had hit him. He said that WN279 had hit him on the head before.

9.335 Ms Hogan also spoke to WN319 and WN214's class teachers who said the children often talked of being hit on the head, although no bruising had been noticed before. They said that the children talked of being hit on the head before WN279's illness, but it seemed to have occurred more often since. On this occasion WN319's "black eye" had been brought to their attention by another resident at the FGH: WN214.

9.336 Ms Hogan also noted that she reported the information to Brenda Chappell (SCCO), who had, along with Charles Smith, discussed the situation with the Housefather WN281. It is recorded that WN281 claimed "*that [WN319]'s black eye had been caused by his getting out of bed in the night and bumping into something*". He had found it impossible to believe that WN279 would hit any of the children, but "*but did show concern when faced with the apparent facts".*

[330] WD009278/23

9.337 On 24 February 1975, Ms Hogan visited the two children, WN319 and WN214. They said this time that the black eye happened while WN319 was sleepwalking, although WN319 said that "*Mummy has hit him on the head before*". WN279 called Ms Hogan later and told her the bruise had been caused by the removal of a splint of fibreglass using tweezers, and she thought that sleepwalking was not very likely.

9.338 In evidence to the Inquiry, WN281[331] said that he remembered one of the children had a bruise but the child was not hit on the head. WN281 had no recollection of a conversation with Brenda Chappell and Charles Smith. He said that although it was difficult for WN279 after her illness, she just would not hit people. He denied the suggestion that he or his wife may have told the children to change their stories.[332] In spite of the contemporaneous record, he said he was never told that WN279 had hit the children.[333]

9.339 As noted in Chapter 4, Ms Hogan made further visits to the FGH in which she criticised the atmosphere of the Home. The Inquiry has not seen any evidence of these reports being followed up at a senior level, or any action being taken.

9.340 **Finding:** The records in relation to the 1975 allegations show an inadequate investigation by Children's Services in response to the disclosures. After some investigation by Ms Hogan, Brenda Chappell and Charles Smith, they appear to have accepted the apparently innocuous (albeit entirely different) explanations given by WN279 and WN281, without properly interviewing the children or involving the police. This was despite other reports about WN279 given by class teachers and Ms Hogan that should have given cause for concern.

<u>Allegations allegedly raised in 1976/77</u>

9.341 A staff member at the FGH, WN287, told the Inquiry that she saw WN319 with a bruise above his left eye and asked how it had happened. He told her "*Mummy did it in the bathroom*". When WN287 was taken to the

[331] Day 137/31
[332] Day 137/31
[333] Day 137/36

contemporaneous records from 1975 (set out above) she said that she believed that it was a totally different incident from the one that she reported[334] to Brenda Chappell. She said that a meeting followed between WN279, Brenda Chappell and Jim Thomson. She went on to say that following the meeting, Brenda Chappell told WN281 that they were concerned about his wife and a decision was made to retire WN279 for ill health rather than to sack her. [335] WN287 thought there was a three-month period between the disclosure and WN279's retirement.[336]

9.342 WN319, in his witness statement[337] also described an incident in which WN279 she pushed him, causing him to fall and hit his head on the side of the bath tub. He developed a black eye. The CO, Charles Smith, came to the house a couple of days later to speak to him. Two people from the Foster Parents Association also attended. He told them about the bath incident and shortly after this he said that WN279 and WN281 left the Home.

9.343 In an SOJP report from 2008, a conversation is recorded with Brenda Chappell noting that her recall was inconsistent to the extent that they would not take a statement.[338]

9.344 WN281 told the Inquiry that the decision to retire was made by him as he considered it was "*probably best*" for them to be in a different environment. He said that if such a meeting had taken place or an allegation raised against his wife, he is confident that she would have informed him. When he suggested retirement to his wife she agreed.[339] He denied that she was forced to retire.

9.345 **Findings:** We think that there was probably a report of physical abuse made by WN287 to her managers in 1977. This concerned a similar assault on the same child as the 1975 allegation. If this second alleged incident did in fact take place, it could have been avoided by proper action in relation to the 1975 disclosure. On the basis that a report was made by WN287, the

[334] Day 76/156
[335] WS000594
[336] Day 76/154
[337] WS000171/4
[338] SOJP officer's report dated 25/09/2008
[339] Day 137/41

response to that complaint was inadequate. The SOJP were not involved, and the children were not interviewed, on the basis of the evidence available to the Inquiry. No records were kept.

9.346 Although there was conflicting evidence on the reason for WN279 and WN281's retirement in 1978, we note WN287's evidence that they were asked to retire in response to the report of assault. If that is the case, it was an inadequate response to an allegation of abuse. Given WN287's evidence, there was also a failure to record the disclosure and to properly inform the Education Committee about the reason for WN279's departure.

Behaviour of visiting clergyman

9.347 There is common ground in respect of one aspect of the evidence, namely visits from a clergyman who engaged the children in a bizarre game. They would bend over his knee and search inside his boots for chocolate while he smacked them on the bottom.[340] WN281 said that the game did take place but if they thought he was doing something inappropriate "*we would have him out the door faster than his feet could touch the floor".*[341] The priest visited every week for two or three years.

9.348 **Finding:** In our view, even by the standards of the day, this was inappropriate behaviour that should have caused the Houseparents to be concerned from the outset.

Operation Rectangle/Redress Scheme

9.349 During Operation Rectangle, WN45, WN31 and WN318 made allegations of physical abuse. Allegations were subsequently made by WN214 in her application to the Historic Redress Scheme.

9.350 WN279 and WN281 were interviewed by the SOJP. WN279's interview was stopped after she gave nonsensical answers (thought by the officers to be in Latin or Gaelic). She was seen by the police surgeon who said that *"she was*

[342] WD008829
[342] WD008829

unable to, or would not, give meaningful replies to questions in interview", despite being fit to be detained and interviewed.[342]

9.351 WN281 in his interview with the SOJP[343] denied the allegations. He said that there was no cruelty and that their own children were disciplined in the same way.

Clos des Sables

9.352 Eight former female residents complained of sexual abuse by Les Hughes, Housefather at Clos des Sables. He was arrested on 23 March 1989.

9.353 Five specimen charges were brought in respect of the allegations made against Les Hughes. He pleaded guilty to sexual offences against WN23, WN282 and WN253. The offences spanned the time from 1969 to 1985 and included three counts of indecent assault, one count of procuring an act of gross indecency and one count of unlawful sexual intercourse.[344] He was sentenced in 1989 to three years' imprisonment.

<u>1988 disclosure</u>

9.354 A contemporaneous document from February 1988 records an interview Marnie Baudains (at that time a CCO not working at the Home) had with WN23 and WN816,[345] two residents at Clos des Sables. Marnie Baudains had been informed by the Duty CCO, Mr Coomer, that WN816 had made a disclosure that Les Hughes had touched her in the "private parts" when they were alone together. Marnie Baudains collected the two girls from the Home and spoke to them.

9.355 WN816 alleged that Les Hughes tried to tickle her between the legs and touched her between the legs. She did not want anything said to Les or Janet Hughes. WN23 said that nothing similar had happened to her. Both girls were then returned to Clos des Sables and the Houseparents were not informed.

[342] WD008829
[343] WS000550
[344] WD000165
[345] WD000191/14

9.356 In evidence to the Inquiry, Marnie Baudains said that she did not recall this incident and thought that WN816 was on another CCO's caseload and her own involvement was as a duty call. She said that the contemporaneous record[346] would have been handed to her Manager. Thereafter it would be for her Manager and WN816's CCO to decide on any further action. She did not know if anything did in fact happen, and the Inquiry has not seen any evidence of any further action at that time. She had not expressed a view in the record of the interview because at that time (1988) she said that she did not have the skills to identify the behaviour as grooming. She told the Inquiry that there must have been some concern because she took the trouble to interview the girls. In oral evidence, she said that she sees it *"so clearly now"* but did not think that she saw it then.[347]

9.357 When Janet Hughes was shown the February 1988 record, she told the Inquiry that she did not remember anything about it, but thought that it should have been brought to her attention. She says that although it sounded *"quite flimsy"* she "*would have wanted to look into it further".*[348]

9.358 **Finding:** The response of the Education Department to the disclosure of abuse in 1988 by WN816 was not adequate. The allegations made by WN816 amounted to disclosures of sexual abuse by a child in care. The fact that the child did not want Les and Janet Hughes to find out does not excuse the inaction that followed this disclosure. Whether this was due to a failure to pass on the report of abuse, or a failure to respond when it was passed on, this was a significant failure on the part of the Education Department.

9.359 Prompt and effective action, like that taken in 1989 in response to WN23's disclosure, would have involved the SOJP. This may have led to the arrest of Les Hughes and his removal from post a year earlier, and thus may have prevented some of his sexual assaults from having taken place.

[346] WD000191/14
[347] Day 91/91
[348] Day 69/98

1989 disclosures leading to prosecution of Les Hughes

9.360 Marnie Baudains gave evidence about WN23's disclosure in 1989 which initiated the investigation into Les Hughes.[349] WN23 was allocated to her caseload in late 1987 or early 1988, and they developed a relationship of trust over the first year. On one occasion when WN23 had stayed out all night, Marnie Baudains visited WN23 her in her bedroom. WN23 told her that Les Hughes had ruined her life and discussed how she had been touched intimately by him from age six to age 11: "*the pain of disclosure was palpable. She had such difficulty in telling me, as if she was wringing the words out of herself*".[350]

9.361 Marnie Baudains said that she believed WN23 and told her straight away, which she thought seemed to matter a lot. She told WN23 that she would have to take the matter further. In evidence, she said that she would have done so even if WN23 had not wanted this to happen. She said there was "*no prescribed guidance*" and "*I had to make an assessment of what to do".*

9.362 Marnie Baudains alerted the member of staff on duty at the Home and then phoned Anton Skinner the same day and he said that he would report the matter. She knew that the police needed to be involved but had had no training and did not know the exact process. After WN23 was interviewed by the police she stayed overnight at Marnie Baudains' house.

9.363 Marnie Baudains told the Inquiry that her priority was WN23. Decisions about other residents at Clos des Sables she left to Anton Skinner, Brenda Chappell and their CCOs to oversee. She thought that the CCO for each child was asked to assess whether the child might have been subjected to abuse. Following this disclosure, she did not recall going back to WN816, who had made the disclosure to her in February 1988, as noted above.

[349] Day 91; WS000618
[350] WS000618/4

9.364 In evidence to the Inquiry, Marnie Baudains said that if a similar situation happened today, there would be greater involvement from other agencies in order to have all of the pieces of the jigsaw in one place.[351]

9.365 **Findings:** Marnie Baudains took appropriate action in 1989 when WN23 disclosed sexual abuse by Les Hughes. As her CCO, Marnie Baudains saw WN23 on a regular basis and a relationship of trust developed such that WN23 felt able to make the disclosure. Marnie Baudains telephoned the CO Anton Skinner who thereafter took appropriate action in response to the report, by passing the matter to the police. Prosecution and conviction followed.

9.366 There was no policy or procedure in place for how to handle reports of abuse. Marnie Baudains' evidence was that there was *"no prescribed guidance*" and *"I had to make an assessment of what to do".* Staff had no training in this regard, as confirmed by Marnie Baudains and WN283. It is implicit in Crown Advocate Whelan's letter that there was no "*fixed policy by virtue of which any complaint, no matter how apparently ill founded, [would] be given formal attention*". On the evidence before the Inquiry, is equally clear that Children's Services took no steps to create one.

<u>WN283's knowledge of allegations of sexual abuse</u>

9.367 WN282 said that she told staff member WN283 who responded that it was best to leave things as they were. The Inquiry understands that this incident founded count five on the indictment to which Les Hughes pleaded guilty.[352]

9.368 There was a further sexual assault on WN282 when she was 14 or 15. WN282 said that she again told WN283 who was reluctant to do anything and said "*think about how Mrs Hughes would feel*". According to WN282, WN283 said that Janet Hughes knew what was going on.[353]

[351] Day 91/92–93

9.369 In her statement to the Inquiry, WN283 said that the girls had told her that Les Hughes used to barge in when they were getting showered and changed and that he used to watch them sunbathing in the garden, but that she *"did not think anything of this*".[354] She told the girls that they should speak to Brenda Chappell if they wanted to take it further. However, "*the girls did not seem to want to do this and that made me doubt whether what they were saying was true*".[355]

9.370 Referring back her statement to the SOJP in 1989,[356] WN283 said in her Inquiry statement that WN253 told her that Les Hughes "*used to play with her*" but she did not understand that to mean that WN253 had been sexually abused. She goes on to say: "*I cannot give a reason as to why I did not take this statement to be a serious disclosure of sexual abuse, all I know is that, at the time, I obviously did not feel that there was anything to it."*[357]

9.371 Another disclosure received by WN283 was when WN282 telephoned her and told her that she had visited the doctor "*because Les Hughes had ruined her life and had been sexually abusing her*". WN283 said in her statement to the Inquiry that she advised WN282 to go to the police. She said: "*I had not received any guidance on what to do should a child disclose allegations of sexual abuse or physical abuse to me*".[358] In evidence to the Inquiry, Anton Skinner said that he was surprised these disclosures were not revealed because of the rapidly developing child protection procedures at the time.[359]

9.372 WN283 said in her statement to the Inquiry that on reflection "*I perhaps should have reported the matter to the police"*, but at the time felt that she should not get involved because the child did not want to pursue the matter herself.

9.373 In her 1989 police statement, WN283 said: *"I thought to myself that it was really up to the girls themselves to either go to the police or somebody at the Children's Office and it was not up to me to go on their behalf."* She went on

[354] WS000725/12
[355] WS000725/12
[356] WD009395/38
[357] WS000725/12
[358] WS000725/13
[359] Day 88/5–7 – Anton Skinner appeared to be referring to the Non-Accidental Injury Procedures

to say that Mr Hughes *"presented the picture of a caring parent and the allegations seemed unbelievable"*.[360]

9.374 WN283 recalled that after the allegations came to light she told Anton Skinner about the disclosures made to her. This was not done in a formal interview and she said: "*Anton Skinner appeared to accept what I was telling him and I continued with my job. I was not told of any disciplinary action. I was not removed from Clos Des Sables and no further action was taken after that meeting.*"[361]

9.375 WN283 thought that Janet Hughes must have known what was going on,[362] whereas Janet Hughes thought that it was WN283's duty to act in response to the disclosures and blamed her for effectively covering up for Les Hughes.[363]

9.376 **Finding:** A number of disclosures of sexual abuse were made during the 1980s to WN283 by girls at Clos des Sables. WN283 took no action. Although her failure to report these disclosures any further may be partly explained by her not having received any guidance on what to do, we consider that this does not absolve WN283. Her evidence was that she thought it was up to the girls themselves to go to the police or someone in Children's Services, and it was not up to her to go on behalf of the children. That is unacceptable, even for the standards of the time. Although we acknowledge that this was an individual decision, as an employee of the Education Department, we conclude that they are responsible for this inadequate response to disclosures of abuse.

<u>Anton Skinner's response</u>

9.377 Following the conviction of Les Hughes, Crown Advocate Whelan, who prosecuted the case, wrote to Anton Skinner the next day:

> *" … Clearly it can be established that complaints were made to* [WN283] *and that she took no effective action. You have indicated that*

[360] WD009395/38
[361] WS000725/16
[362] WS000725/15
[363] WS000578/32

> *you will wish to look further into the matter. If you are satisfied that* [WN283]*'s response to the complaint was at fault you will no doubt wish to consider what action should be taken. In addition, you will no doubt wish to give thought to establishing a fixed policy by virtue of which any complaint, no matter how apparently ill founded, will be given formal attention."*[364]

Crown Advocate Whelan concluded:

> *"I should welcome a note of your conclusions in due course."*

9.378 On 11 October 1989, in an article published in the JEP, Anton Skinner said that he would prepare an in-depth report into what had happened. The report would consider whether there were any lessons to learn for the future and how this had remained undetected for 20 years.[365]

9.379 Anton Skinner gave evidence to the Inquiry that there was no review.[366] He later said that he suspected that there was a report but was quite sure that it would not have revealed any "*nuggets of how better to detect abusers in care settings".*[367] The Inquiry has seen no document appearing to be such a report.

9.380 Anton Skinner also said that *"if* [WN283] *was still employed by us and had failed to report a serious case of abuse then I would have thought that was grounds for dismissal".*[368] As noted above, no disciplinary proceedings were instigated.

9.381 **Findings:** Anton Skinner's failure to follow up the sound advice he received from Crown Advocate Whelan to look further into the matter of WN283's inaction, and his failure to follow up on own assertion to the JEP that he would prepare an in-depth report into what had happened, are both inexplicable, and his explanation to us was unconvincing.

9.382 He said that the report would consider whether there were any lessons to learn. At the time, there was no policy in place for managing allegations of abuse against staff, or managing allegations by children in care. He had the

[364] WD005567
[365] WD005572/36
[366] Day 88/10
[367] Day 88/61
[368] Day 88/7

perfect opportunity, in 1989, to conduct a review that may have led to a policy being created. He said he would conduct such a review, but did not. As a result, not only was there no policy in relation to Clos des Sables, there was none for any of the FGHs.

9.383 Further, the Education Department's failure to take any disciplinary action against WN283 was inadequate. Anton Skinner accepted in evidence to the Inquiry that her conduct was grounds for dismissal. Despite having full knowledge of this conduct at the time, no action was taken. This was another failure to grapple with the inappropriate response to disclosures of abuse.

Evidence of Janet Hughes

9.384 Janet Hughes gave evidence to the Inquiry that she had no suspicions about her husband at any stage until she was told of the allegations in 1989.[369] The staff at Clos des Sables had never raised any concerns with her about her husband. She said that if an allegation of sexual assault had been made to her, she would have involved Children's Services and the police.[370] Following the disclosures in 1989, Janet Hughes left the Home immediately and her husband was arrested.

9.385 Janet Hughes told the Inquiry the discussions she had with Children's Services were not about what had been happening at Clos des Sables. It was her employment position that was discussed on the basis that although there were no allegations made against her, she could not continue to work at Clos des Sables.[371]

9.386 Janet Hughes denied the allegation that she asked WN148 to leave the Home following WN148's disclosure to staff member WN283. She said that she "*would never have just thrown a resident out of the house without having a plan for their after-care".* [372]

[369] Day 69/90
[370] Day 69/86
[371] Day 69/92
[372] Day 69/86

Blanche Pierre

Background to disclosures

9.387 In late 1989/early 1990, two trainee child care staff, Susan Doyle and Karen O'Hara, were placed at Blanche Pierre.

9.388 Susan Doyle initially provided holiday cover at Blanche Pierre for six weeks. She thought that she would be looking after the children but recalls that in fact she did the chores at the FGH. She turned down a subsequent offer to work at Blanche Pierre full-time, instead taking up a part-time role. She said that Jane Maguire had initially come across as "*quite a caring person"* but she was reluctant to take the job because she had concerns about the way the children were treated:

> *"The strictures of the home, the way that Jane and Alan spoke to the children, the rules of the home and it was just my gut feeling … It was in stark contrast to how they presented to the public or the Children's Office. They were quite cold. They did not display warmth or affection and they really did not have any empathy towards the children."*[373]

9.389 Her role was made permanent in February 1990. The atmosphere in the Home, she recalled, was "*quite tense*" and she could see that the children were "*fearful*" of the Maguires: "*They would freeze when spoken to by Jane. They would freeze."*[374]

9.390 Susan Doyle described to the Inquiry her recollection of Alan Maguire, whom the children referred to as "Big Alan". "He bragged about how he would lift the children up by the ears for a bit of fun and the youngest was walking past and he demonstrated in front of me. The child, aged seven years, was held up in the air probably for a couple of seconds". She told the Inquiry that the child had done nothing wrong.

9.391 According to Susan Doyle, the Maguires slapped the children and shouted at them in front of her. She said there was very little she could do apart from comforting the children afterwards. Susan Doyle witnessed other incidents

[373] Day 82; WS000604; WD006633
[374] Day 82/9

and described one in particular which she overheard and then witnessed the aftermath:

> *"Bad language was not allowed and it was a house rule that he would wash their mouths out with soap and on that particular time the youngest boy swore and he marched him off to the downstairs toilet where I could hear screams behind the door and when he came out the young boy … was sobbing and he had cut his tongue at the side … I went to comfort him … I was shouted at (by Alan Maguire) … 'Keep away.'"*

9.392 On Friday nights, Susan Doyle slept over at Blanche Pierre. On one occasion, she recalled a child aged nine years being made to stand by the front door in their night clothes, facing the wall. This incident lasted for "*two hours*" before Alan Maguire decided that the child could go to bed. According to Susan Doyle, the Maguires spoke to her about the children in derogatory terms such as: *"a slut like her mother*". They never said kind things to the children.

9.393 Susan Doyle told the Inquiry that during mealtimes the children were not allowed to speak unless spoken to and the food had to be eaten otherwise it was served up again the next day. If the children misbehaved or talked out of turn, Jane Maguire banged their heads together. Alan Maguire would do the same. Susan Doyle, a mother herself, questioned Jane Maguire about her treatment of the children and was told: "*I'm their foster mother and this is the way we treat these kind of children.*"

9.394 Susan Doyle felt at the time that she could not take the matter any further as she had just started working for Children's Services as a "*very junior member of staff*" and "*I had no experience in child care*". Susan Doyle felt that she could not raise her concerns about the Maguires with Brenda Chappell. Likewise, she was unable to speak to Richard Davenport, a CCO who visited Blanche Pierre, because *"Jane was usually around*".

9.395 Susan Doyle remembered making entries in the Blanche Pierre Home Diary that staff were expected to complete. Entries in the diaries record the punishments the children received but Ms Doyle said that "*nobody checked the diaries*". She could not explain why the Maguires kept this form of diary

and thought that it was "*probably*" not a complete record of the punishments given to the children.[375]

9.396 The other staff who had been there longer "*seemed to accept the behaviour without question*" according to Susan Doyle. She sensed that the Maguires were under pressure; "*they did not have the ability to cope*" but added, *"it does not excuse their behaviour and their cruelty*".[376] Susan Doyle said that there was daily contact between Jane Maguire and Brenda Chappell and that their relationship was both professional and personal. She never heard Jane Maguire mention that she was under any pressure or stress.[377] Susan Doyle felt that there was a lack of support from Children's Services but added that had it been offered "*they would have refused it … They did not want anybody else within the home".*

9.397 Karen O'Hara was no longer alive at the date of the Inquiry. She provided a statement to the police in November 1997.[378] Her account of what she witnessed is similar to that given by Susan Doyle: "*I have seen Jane smack all of the children … Punitive and vindictive … There was no compassion in the house."* She saw Alan Maguire smack a child who then wet herself.

9.398 Karen O'Hara told the police that Alan Maguire had a particular dislike of WN88. On one occasion WN88 was told to clean and tidy the playroom while Karen O'Hara was washing at the sink. Alan Maguire went into the playroom "*screaming and shouting*". Karen O'Hara then "*saw Alan pick up WN88 and hurled him across the room, about ten or 12 feet. WN88 hit the wall under the window looking out to the garden, on his back. I was worried that he be seriously injured because he was so small … Alan told the other kids and they laughed".*

<u>Disclosures made by Susan Doyle and Karen O'Hara (1990)</u>

9.399 While working at Blanche Pierre, Susan Doyle and Karen O'Hara were both attending an Open University residential care training course co-ordinated by

[375] Day 82/52
[376] Day 82/77
[377] Day 82/98
[378] WD006354

Dorothy Inglis, a member of Children's Services social work team. Dorothy Inglis spoke to the Housemother, Jane Maguire about the training, and noted that:

> *"Jane Maguire was not receptive to this training opportunity and was concerned that Sue and Karen will be taking time out of their duties at Blanche Pierre."*[379]

9.400 At one of their fortnightly tutorials, when discussing corporal punishment, both raised their concerns with Dorothy Inglis about their experiences at Blanche Pierre.

9.401 Susan Doyle explained the timing of her disclosure:

> *"It was with being such a junior member of staff. Would I be believed? What proof did I have? … It was only when I started working there permanently that I started to make notes of incidents to build up some proof to take it forward … It took time to gather that evidence because I knew I wanted to be believed".*[380]

9.402 Audrey Mills, in her witness statement,[381] recalled Karen O'Hara coming to her for advice having seen a child badly treated by Alan Maguire. Karen O'Hara, she said, was unsure how to proceed and she advised her to speak to Dorothy Inglis, "*a very experienced social worker at the time*".

9.403 According to Susan Doyle, Dorothy Inglis then drafted a statement "*which we both signed*". Susan Doyle remembered feeling relieved that they had disclosed their concerns. Dorothy Inglis said that they had done "*the right thing*" although Susan Doyle said that she remained fearful for her job.

9.404 Dorothy Inglis was "*absolutely horrified and quite shocked*" on hearing their accounts. She made a contemporaneous handwritten note of everything reported to her and went to see Anton Skinner (CO) immediately after Susan Doyle and Karen O'Hara left.[382]

[379] WS000629/20

[380] Day 82/92
[381] WS000585
[382] WS000629/21

9.405 The Inquiry has both a manuscript[383] and a typed note[384] of that meeting with Dorothy Inglis. The "*Report for Mr AJ Skinner, outlining information received Le Squez Family Group Home*" begins with an assessment of Susan Doyle and Karen O'Hara. Dorothy Inglis describes them as "*intelligent, enthusiastic and caring people*". The disclosure is presented in three parts; first, regarding specific incidents; secondly, general incidents; and, thirdly, general issues relating to staff and household. The report concludes:

> *"They have/do feel very isolated and confused and they read that no corporal punishment is used by the Children's Department then they see it happen – perhaps foster parents are allowed to smack children? Jane states clearly that she is the children's foster parent – perhaps that is the explanation.*
>
> *Ms O'Hara and Ms Doyle are greatly concerned and anxious about the situation and I feel that they have taken the most difficult route in mentioning what has happened rather than simply opting out. They naturally now feel very vulnerable".*

9.406 Dorothy Inglis told the Inquiry that at the meeting, Anton Skinner said that he would deal with the matter although he did not tell her what he was going to do. There was no mention of involving the police and there was no reference made to the welfare of the children at Blanche Pierre.[385]

9.407 Dorothy Inglis told the Inquiry that she contacted Anton Skinner "*three or four days later*" for an update as she had not heard from him. She says that she was "*put out*" by his comments about Susan Doyle and Karen O'Hara: "*I remember him saying that they had not been in the post for very long and the indications were that perhaps they were not … necessarily going to be that good at the job.*" Dorothy Inglis thought that the comment had been given to him: "*I do not know from whom.*" She said that she just responded by saying: *"you do not have to be in a job a long time to know what good practice is and that's certainly not good practice*". His response, she said, was to tell her that "*Blanche Pierre was not my concern".*[386]

[383] WS009305
[384] WD000206
[385] Day 97/86
[386] Day 97/89

9.408 Dorothy Inglis thought that there would be an investigation and that the children would be the primary concern, ensuring "*the best possible support and best possible outcome for them*". She thought that there should have been an investigation at that time.

9.409 Susan Doyle recalled that, shortly after seeing Dorothy Inglis, she and Karen O'Hara were called to a meeting with Anton Skinner in his office. Anton Skinner said that he took the allegations "*quite seriously*" and acknowledged the difficult route taken in bring it to his attention. Anton Skinner "*reassured us that our jobs were safe and he would deal with it in due course".*

9.410 A three-page document[387] is headed "Record of Notes taken during an interview at the Children's Office on twenty-seventh of April 1990 with Ms K O'Hara and Miss S Doyle both of Le Squez Family Group Home related to events alleged to have taken place at the Home". The interview was conducted by Anton Skinner, CO and Geoff Spencer, Senior Officer. The text of the record follows closely the note prepared by Dorothy Inglis and additional allegations are recorded in the text at paragraph 13 (a)–(r). The account witnessed by Susan Doyle of a child being thrown across the room is dated 20 April 1990, seven days before the meeting with Anton Skinner.

9.411 At the meeting on 27 April 1990 no mention was made about what would happen to the Maguires. Susan Doyle said she continued to work at Blanche Pierre *"for the children … I was hoping for better outcomes for them*".

9.412 On 30 April 1990, Anton Skinner had a meeting with Jane and Alan Maguire and recorded the details in a report dated some three months later, on 6 August 1990.[388] That report refers to *"two further interviews which were conducted in May and June".* The chronology of events after 30 April 1990 is a matter of controversy since it is unclear what event in fact precipitated the decision taken by Anton Skinner to remove the Maguires from Blanche Pierre.

[387] WD000205/3
[388] WD000207

9.413 Susan Doyle said that following her meeting with Anton Skinner, Geoff Spencer took over from Brenda Chappell in overseeing Blanche Pierre. She said that "*Brenda Chappell went off on long-term sick leave*". According to her, Geoff Spencer told the staff that he was sending in auditors: "*Jane was in a state of panic*". Susan Doyle told the Inquiry that Jane Maguire was sent "*on lots of training courses*" but was still running Blanche Pierre.[389] Geoff Spencer's evidence was that he had no recollection of being involved in the investigation of the Maguires, despite Susan Doyle and Karen O'Hara stating that he was present at an interview with them. He did remember asking to look at the accounts and expenditure as part of his general oversight role.[390]

9.414 The next event in the chronology involved Susan Doyle. When she was on a Friday evening shift, WN154, a 15-year-old resident, did not come back to the home. She said that Alan Maguire "*openly bragged what he would do to him when he got his hands on him*". Susan Doyle was concerned for WN154's wellbeing so contacted Dorothy Inglis who in turn contacted Geoff Spencer.[391]

9.415 Susan Doyle told the Inquiry that she was instructed to meet WN154, on the Saturday morning, and give him the option of going home with her or returning to Blanche Pierre "*to face the music*". Susan Doyle said *"he faced Alan's wrath as he went in and he went up to his bedroom, jumped out of the bedroom window … and came to my house at 10 o'clock at night".*[392]

9.416 She described WN154 as being "absolutely terrified" and "in a bad way emotionally". She said that he was "terrified because he knew eventually he would have to go back there but he did not know that I had already disclosed to Anton". Geoff Spencer came to her house and said that he would speak to Anton Skinner. WN154 then spent four nights at Susan Doyle's house during which time she was not required to work at Blanche Pierre. It is noteworthy that there are no contemporaneous Social Service records recording these events.

[389] Day 82/66
[390] Day 75/55–66
[391] WS000604/13
[392] Day 82/69

9.417 Susan Doyle told the Inquiry that she believed the incident involving WN154 was the precipitating event that led to the removal of the Maguires from Blanche Pierre. Anton Skinner asked her to collect the keys from the Maguires, which she thought "*should never have happened".* An entry written in the records by Richard Davenport (CCO) dated 1 June 1990 suggests that by this date the Maguires had left (with Audrey Mills having taken over), and that WN154 running away was the event that led to their departure. The record is noted by Anton Skinner on 12 June 1990, who wrote "*please discuss".* [393] Susan Doyle said that not enough was done by Children's Services at the time to give support to the children at Blanche Pierre.

9.418 When the Maguires left Blanche Pierre, Susan Doyle said that she had another meeting with Anton Skinner. Her account was that he asked her to remember all the good work the Maguires had done. She recalled that he advised her and Karen O'Hara "*to keep quiet because the other Family Group Home was about to go into the paper regarding the abuse and the Island would not be able to cope with it".*[394] The other FGH referred to was Clos des Sables, where Les Hughes had been the Housefather and had been arrested a few months beforehand.

9.419 Anton Skinner said that he "*probably"* drafted a letter dated 26 July 1990 which was signed by Iris Le Feuvre, President of the Education Committee, and sent to Jane and Alan Maguire. The letter thanked the Maguires for their excellent work and total commitment to the children in their charge. The letter continued:

> *"It is therefore with regret that we learn of your retirement although we fully appreciate that after ten years of extremely hard work for our children a change of direction and a rest from the twenty-four hours a day commitment you have shown over all these years was well deserved. My committee therefore asked that I write on behalf of the children in your charge and to wish you all the very best for your future. We were delighted to learn that Mrs Maguire will continue to work for the Committee in our developing Family Centre Service and therefore we would not be losing your services altogether. Once again many*

[393] WD000408
[394] Day 82/93

thanks for your 110% commitment and hard work, the proof of which will live on in the children for whom you have shown such love and care."[395]

9.420 At the date of the letter, 26 July 1990, Anton Skinner had had three meetings with the Maguires which he then wrote up in the report dated 6 August 1990. Anton Skinner said in his statement to the Inquiry that the letter was "*all balderdash"* and in oral evidence said that it was a demand made by the Maguires – "*they wanted something that they could show the parish priest or the family*". He said he discussed the letter with Iris Le Feuvre and that he would have told her about the circumstances – "*what was going on in negotiations with the Maguires … I would have discussed the allegations that had been laid by the two members of staff*". He accepted that he was asking the President of the Education Committee to sign a letter which he knew to be false: "*I produced a letter that was part of the arrangements for removing them."* In Anton Skinner's view, the Maguires were in a state of denial. In a 2008 statement to the SOJP, Iris Le Feuvre said that she could remember signing the letter but could not remember the contents of the letter. She told the police: "*I would not have signed it without reading it first.*" She told the police that she could "*definitely remember some discussions within the committee in relation to* [the Maguires]".[396]

9.421 Jane Maguire was re-employed in the Family Service Centre as a family centre assistant and development officer. This role involved contact with young children on a regular basis. She was also employed to give parenting advice. When the Maguires left Blanche Pierre, Anton Skinner asked Audrey Mills (CCO) to go there. Audrey Mills said that she had no idea at the time that she was asked to take over the running of the Home, that Jane Maguire would be taking up Audrey Mills' previous job. Anton Skinner simply told her that there had been mismanagement at Blanche Pierre. She was not involved in any arrangement to exchange roles with Jane Maguire. She said

[395] WD000213
[396] WD006865

that the description set out in Anton Skinner's 6 August 1990 report was "*inaccurate*".[397]

9.422 Anton Skinner's two-page report is reproduced in full below:

> *CONFIDENTIAL DOCUMENTS*
>
> *Group Home Le Squez – Mr and Ms Maguire*
>
> *Discussed the allegation contained in the Record of Notes taken on 27 April 1990, with Mr and Ms Maguire, on 30 April, at Highlands College.*
>
> *Mr and Ms Maguire denied the degree of physical contact/the verbal threats and inappropriate punishment – Mr Maguire was particularly angry and adamant that the incident of 20 April witnessed by Ms O'Hara had not occurred in the manner described. He alleged that Ms O'Hara had grossly exaggerated the details of this incident and that in reality [WN88] slipped when half pushed towards the area of the playroom he had been asked to tidy up.*
>
> *The House parents admitted that they had employed what they termed "slaps on the back of the legs" and "run a-longs" as means of physical punishment for perceived wrongdoing/naughtiness by the children. They also admitted that they had used washing mouths with soap as a means of punishing the children for using bad language. They maintained that all the methods of punishment they used would be that used to discipline their own children and they consider these punishments appropriate in the rearing of children.*
>
> *Initially they challenged whether they had been told that it was the Children's Service's policy that corporal punishment was never used as a means of disciplining children in the Care of the Education Committee but later they appear to retract the statement.*
>
> *A period of time was spent with Mr and Ms Maguire trying to put these alleged incidents in what they saw as their true perspective set against the years of loyalty and commitment they had demonstrated to the children in their care. The couple also made various criticisms of Ms Doyle and Ms O'Hare's attitude to, and care of, the children although no complaint of any substance was made.*
>
> *In the final part of that interview and two further interviews which were conducted in May and June the following was agreed:*
>
> *1. The fact of the use of corporal punishment by Mr and Ms Maguire was admitted although they maintained that only light "slaps" or "taps" on the legs were used.*

[397] WS000585; WD006313; Day 73

2. They accepted that there may have been an overemphasis on "controlling" the children and that inappropriate sanctions/threats of removal etc. may have been used.

3. It was acknowledged that much of this behaviour reflected the increasing pressures on Mr and Mrs Maguire trying to raise children who were emotionally damaged and so exhibited behaviour which they found difficult to cope with. In effect the couple were experiencing the early signs of possible "burnout".

4. It was agreed that it would be better for Mr and Ms Maguire to consider "retiring" from the role of House parents before the acknowledged pressures resulted in possible deterioration in their standards of care for the children.

Subsequently a handover of responsibility from Ms Maguire to Ms Audrey Mills was agreed and was staged during May/June with Mr and Ms Maguire effectively "retiring" as Houseparents of the Group Home at the end of June. Ms Mills has now been appointed as Officer in Charge of the Group Home with a staff complement of 4 ½ to be established as soon as possible. There will be no resident member of staff but staff will provide the sleep-in cover required for the Home.

Jane Maguire has now taken up Ms Mills' former position within the Family Centre Service as Family Centre Assistant and Development officer this effectively a "job – swap".

AJ Skinner

AJS / SJR

Children's Officer

6.8.90

9.423 Audrey Mills said there was no formal handover when she moved into Blanche Pierre, and she did not meet the Maguires. Although they had run the home for nearly 10 years there were no written reports and no photographs of the children. She felt that she would have benefited from more support and professional guidance at the time.

9.424 Audrey Mills was shown, in advance of her evidence to the Inquiry, the letter to the Maguires signed by the President of the Education Committee, Iris Le Feuvre. She had not seen the letter in 1990 and 25 years later she told the Inquiry that she felt "*very angry when I read that*".[398]

[398] Day 73/41

9.425 Dorothy Inglis told the Inquiry that she felt that Brenda Chappell "*had a large part to play*" in the decision to re-employ Jane Maguire. She knew that Brenda Chappell held the Maguires in "*very, very high regard*" and remembered her calling Mrs Maguire "*Janie*". She said that Brenda Chappell was a strong force within the Department and "*was always very very very supportive of the people that she was responsible for*".[399]

9.426 Once the Maguires left Blanche Pierre Dorothy Inglis said that it became general knowledge that they had mistreated children in their care. When Jane Maguire was redeployed in Children's Services, Dorothy Inglis told the Inquiry that her colleagues were *"horrified*" and organised an informal meeting with Anton Skinner in which she took part. David Dallain, Richard Davenport and David Taylor (all CCOs) also attended the meeting to express the collective view that it was *"highly inappropriate to re-employ [Jane Maguire] in advising mothers or parents on good parenting practice*". Dorothy Inglis said that Anton Skinner responded *"emphatically*" that it was not their decision to make.

9.427 Dorothy Inglis said that she lost faith in Anton Skinner at that point, albeit that he had been her line manager from the time she joined Children's Services. She said: "*I had a great deal of respect for him and I just feel that the situation, he handled so badly that yes, I lost a lot of faith and sometimes it is difficult to rebuild that.*"[400]

9.428 **Findings:** In 1990, when the care workers Karen O'Hara and Susan Doyle raised their concerns about abuse at Blanche Pierre, there was no formal process in place in Jersey for staff to disclose concerns of abuse. Additionally, there were no formal policies or procedures as to how such disclosures should be handled once received. Formal policies and procedures relating to the disclosure of abuse were in place in Social Service departments in the UK at that time. The absence of such procedures in Jersey at this time was inadequate. This contributed to the failures in the response to the allegations made about the Maguires.

[399] Day 97/102
[400] Day 97/100

9.429 In the climate of that time, the action of Karen O'Hara and Susan Doyle in reporting allegations of abuse was courageous and should be commended. Dorothy Inglis, in pursuing the matter, displayed a responsible and professional attitude for which she too should be commended. The response of all three to concerns about abuse was more than adequate.

The role of Anton Skinner in response to the allegations of abuse in 1990

9.430 Anton Skinner gave evidence to the Inquiry over three days in July 2015. Part of his evidence dealt with his role in the disclosure of abuse at Blanche Pierre.[401] He gave evidence after Susan Doyle but before the Inquiry heard from Dorothy Inglis and Dylan Southern.[402]

9.431 Anton Skinner was therefore given the opportunity to respond to their evidence and he provided a supplementary 38-page statement to the Inquiry in February 2016. [403] This statement in part seeks to counter some evidence given by Dorothy Inglis, Dylan Southern and Susan Doyle. We have considered his supplementary statement in full and in particular with reference to the handling of the Maguires' case in 1990 and subsequent events in 1997–1999.

9.432 Anton Skinner had been CO since 1986. He had overall responsibility for the social services for children both for those at risk and those in care. This included those in residential children's homes, foster care and FGHs. He was directly answerable to the Education Committee and the Director of Education (John Rodhouse).

9.433 In 1983, when he was a SCCO, Anton Skinner compiled a three-page list of non-accidental injuries which had been referred to other agencies, including the police and Health Visitors.[404] These included four cases of "*excessive physical force used in disciplining children … which involved mitigating factors or provocative actions by the children involved".* All of these took place in the family home. In evidence to the Inquiry, Anton Skinner agreed

[401] Days 87–98
[402] Dylan Southern was appointed in 1997 by the Chief Executive of the HSSD to report on whether there was a disciplinary case against Jane Maguire
[403] WS000734
[404] WD007092/53–55

that the list was representative of cases that would have been referred by Children's Services to the CPT.[405] He accepted that the account of a boy being thrown across the room "*if it is received just as an allegation it would have been handed to the Child Protection Team for investigation*".[406] He explained to the Inquiry why the specific allegation made in 1990 by Karen O'Hara about WN88 was not referred to the CPT:

> *"Because that was an allegation that I and the person supervising at the home at the time took up with the house parents."*[407]

9.434 Anton Skinner also explained to the Inquiry what he considered to be the exceptional nature of the situation that he faced with the Maguires, not least of which was, according to him, the number of children in the Home:

> *"I wished to remove [the Maguires] from the Group Home with the least amount of collateral damage to the children."*[408]

When asked again why the allegations against the Maguires had not been referred to the CPT, he told the Inquiry:

> *"it was an extremely complex situation".*[409]

9.435 He said that his last visit to the home was *"some months before"* he received Dorothy Inglis's report in April 1990. He told the Inquiry that *"my presence in the home had been used by Alan Maguire to lecture a child in front of me about what would happen to that child if you continue to behave badly and 'this was the Children's Officer there' and I remember leaving the home thinking 'I do not like that attitude' and I had mentioned that to the senior member of staff that I considered it inappropriate".*[410] He said that he did not speak to Alan Maguire at the time about his inappropriate attitude. He added that he had not been intimidated by Alan Maguire and spoke to Brenda Chappell *"about it a while later"*.[411]

[405] Anton Skinner's evidence was that the CPT was formed in about 1985, although other evidence suggests that this occurred around 1989
[406] Day 87/153
[407] Day 87/151–157
[408] Day 87/154
[409] Day 87/156
[410] Day 88/18
[411] Day 88/114

9.436 Anton Skinner told the Inquiry that any concerns that others may have had about the Maguires were allayed by the support they received from Brenda Chappell. Brenda Chappell never raised concerns with him and, he said, "*probably held the view that they were struggling to do their best throughout*". When shown Jane Maguire's 1987 self-assessment, he agreed that it did not portray someone who was struggling.

9.437 Anton Skinner said that Susan Doyle and Karen O'Hara had been "*very brave and professional in coming forward … and had acted properly*". On receipt of Dorothy Inglis's report he did not speak to Brenda Chappell at that stage but contacted Geoff Spencer, who was then supervising the FGHs in Brenda Chappell's absence. He too was shocked at reading what was said about the Maguires: *"it is an appalling litany of behaviours towards children".*[412]

9.438 Anton Skinner was invited to comment upon the schedule of house diary entries.[413] He said he would have expected Brenda Chappell to have looked at those diaries on a routine basis. If the entries had been brought to his attention, *"I would have been dismayed by the whole retinue of crude punishments … this was an unsatisfactory arrangement for children*". He told the Inquiry that he would have "*removed the Maguires as effectively as I could in the shortest possible period of time".* The entries were, he said, *"an appalling catalogue of ways of responding to children's misbehaviour".*[414]

9.439 By way of example, a Home Diary entry for 13 September 1986 records: *"slapped on backside with my sandal and later still (they) carried on in the hall, and in future when I'm on duty they will not go to bed, but will stand until they beg to go"*.

9.440 Anton Skinner was invited to compare and contrast his August 1990 report with his written statement prepared in January 1999 for the internal disciplinary review conducted by Dylan Southern. In the 1999 statement he sought to distinguish the 1990 accounts of the Maguires' behaviour from the

[412] Day 88/46
[413] WD007092/16
[414] Day 88/35

accounts obtained by the police in 1997/98. The latter included allegations of sexual assault by Alan Maguire. He said: [415]

> *"An examination of these second set of alleged offences, set against the original complaint made against the Maguires, bear little or no comparison. The first reflect a couple losing control in a single instance allied to misgivings about their competency to care for damaged children. The second set of allegations, which are believed by all those in the investigation to have taken place, detailed a catalogue of cruel and sadistic treatment of vulnerable children placed in trust in their care. They also clearly portray what Ms Maguire thought was acceptable treatment of vulnerable persons in her care."*

9.441 He accepted, however, that the account given by Susan Doyle and Karen O'Hara was *"a catalogue of cruel and sadistic treatment".* He told the Inquiry that the situations in 1990 and 1999 were "*vastly*" different, "*not in terms of the content of the allegations but the circumstances in which they may or may not have been corroborated by the children".*

9.442 When asked whether Jane Maguire should have been dismissed in 1990, Anton Skinner replied:

> *"I did take a pragmatic course of action which resulted in Mrs Maguire working in the Family Centre Service in which, you may say, 'why was she not disciplined and dismissed?' and with the hindsight of the children saying all of these things happened, if they were not in day-to-day direct care of the children at that time then yes that may have been possible to achieve that through disciplinary action and dismissal. I dealt with a set of situations based on what Karen and Sue Doyle were saying and what the Maguires was saying in response to that and I wanted to keep the children neutral to that because these were their parents, or house parents, living on a daily basis with them, with their direct care."*[416]

9.443 From a number of Anton Skinner's answers in evidence, his rationale seems to have been that he sought to protect the needs of the children by not sacking Jane Maguire while she was still in the FGH. He was then asked why, when she left the FGH, she was redeployed in Children's Services rather than being dismissed at that point. He replied: "*this was presented to me as an alternative that would have eased her out of the Group Home with*

[415] WD007092/150
[416] Day 88/75

her full compliance and co-operating with the handing over of the Group Home to another set of staff".

9.444 He accepted that it was his suggestion and choice of phrase – used in the Confidential Notes – that the Maguires should "*retire*". Anton Skinner had commented elsewhere in his statement to the Inquiry that the States "*were not very good at firing people*". Having accepted that Mrs Maguire would ordinarily have been dismissed in 1990 for what was reported, he was asked whether his approach to the Maguires in 1990 stemmed from the general cultural difficulty of sacking people. He agreed he could have commissioned a disciplinary hearing. He did not at the time make it clear to the Maguires that had it not been for the circumstances he would have taken disciplinary action "*because*" he said, "*they had not seen themselves as these transgressors ... they had denied the majority of those offences*". He accepted that, with hindsight, he had been lenient with the Maguires.[417]

9.445 Anton Skinner was asked what action he took to protect the children in the three months the Maguires remained at Blanche Pierre after the April 1990 disclosure. He said that he told the Maguires "*firmly and properly*" that they could not "*use the methods of discipline that they had*". During the period *"we negotiated their exits*", the Maguires were *"very closely monitored and visited by others, Child Care Officers and Geoff Spencer".*

9.446 When it was suggested to Mr Skinner that his priority in 1990 had been the Maguires and not the children, he told the Inquiry that "*getting the Maguires out as soon as possible*" was his priority. Mr Skinner was referred to the document dated 6 August 1990 (reproduced above). He agreed that the meetings in May and June referred to in the notes concerned negotiations with the Maguires about their withdrawal from Blanche Pierre in what was the best achievable outcome for them. He told the Inquiry that it was his "*recollection*" that Brenda Chappell had taken part in what he described in evidence as "*the negotiations*".

[417] Alan Maguire was not an employee of the States, so could not have been subject to disciplinary proceedings

9.447 He accepted that the reference to "burn out" in the notes was not an expression the Maguires used in explaining their actions. He did not accept that the reference to "burn out" was an ex post facto rationalisation made by him to justify the approach he took in 1990. He told the Inquiry:

> *"I did what I thought was achievable and possible at the time if that was all in error and I should have taken other actions then obviously I accept that is a matter for the Inquiry."*[418]

9.448 Anton Skinner said that the decision to remove the Maguires was taken following his meeting with them on 30 April 1990 and not following the incident with the resident WN154 running away. He accepted that he had been concerned at the time that disclosures about Blanche Pierre reflected badly on Children's Services but said that protecting its reputation was not *"my primary concern at all … very much a minor issue".* He was asked about a passage in his 1999 statement in which he referred to Children's Services recognising a "*contributory responsibility*" for what had happened. He told the Inquiry that he was not referring to a lack of supervision by Children's Services but to the decision to maintain FGHs.

9.449 Anton Skinner acknowledged that in 1990 he did not refer the matter to the CPT nor to the police and that the children had not been interviewed. Furthermore, he did not consult the Director of Education. He was asked whether in those circumstances there was a "*cover up*" and he replied:

> *"Well if you are describing what would constitute a cover-up then clearly it was in those terms a cover-up. But not something that I would have seen as a cover-up, it was something I would have seen as trying to deal with the situation as quickly as possible."*[419]

9.450 Had any investigation been instigated by Anton Skinner, it is possible that the Home Diaries and other allegations would have emerged at that time.

9.451 Anton Skinner told the Inquiry that the letter[420] signed by the President of the Education Committee was "*probably drafted*" by him. He said in his statement to the Inquiry[421] that the letter was "*all balderdash*" and he said in

[418] Day 88/102
[419] Day 88/135
[420] WD000213
[421] WS000614/33

evidence that it was a demand made by the Maguires – "*they wanted something that they could show the parish priest or the family".* He accepted that he was asking the President to sign a letter which he knew to be false: "*I produced a letter that was part of the arrangements for removing them".*

9.452 At the close of his evidence to the Inquiry, Anton Skinner made a statement, part of which reads:

> *"I do think it important and wish to make an apology on both my behalf and my Services behalf to the residents of Blanche Pierre Group Home that we did not pick up the alleged abuse that they suffered prior to Sue Doyle and Karen O'Hara coming forward. That was an error of our organisational structure at the time and I offer unreserved apology to those children that suffered as a result of us being lax in detecting those things earlier."*

9.453 **Findings:** Anton Skinner's responsibility as the CO was to the children in care at Blanche Pierre. He claimed to the Inquiry to have been fulfilling that responsibility. He failed to investigate fully the allegations of abuse or to take appropriate action. He should have ensured the immediate removal of the Maguires pending a thorough investigation. His failure to do so left the children exposed to the risk of harm for a period of months and compromised later attempts to deal with the Maguires.

9.454 The disclosures of abuse should have been referred to the CPT and the SOJP should have been notified. The States of Jersey, in their closing submissions,[422] recognised that "*those in authority failed to report the suspected physical abuse to the States of Jersey Police. It must be acknowledged that there were inappropriate responses in 1990/91 to the reported serious concerns of physical abuse, with devastating consequences for the vulnerable children concerned".* We agree. Anton Skinner's explanation for failing to notify the CPT was not convincing.

9.455 Anton Skinner failed to consult the Director of Education or the Education Committee about the disclosure of abuse and his negotiations with the Maguires. He agreed an exit strategy that gave priority to the interests of

[422] Day 145/52

Jane and Alan Maguire rather than to the care and protection of the children concerned. That approach was, in our view, unprofessional.

9.456 The children at Blanche Pierre and other staff working there should have been interviewed at the time of the disclosures in 1990. In the absence of the matter being passed to the SOJP, this investigation should have been carried out by Children's Services. The failure to do so was inadequate and meant that contemporaneous evidence was never obtained from those who were resident at the Home.

9.457 The Education Department failed to take disciplinary action against Jane Maguire at the time of the disclosure, and instead redeployed her in a post which involved her giving parenting advice, despite the objections of CCOs. This was, in our view, inexplicable and indefensible. It also reflects a broader attitude within the Department at that time, of taking the easier route rather than the correct one.

9.458 The letter drafted by Anton Skinner and sent out by Iris Le Feuvre on behalf of the Education Committee, which thanked the Maguires for their "*110% commitment"*, was indefensible. It represented a whitewash of the allegations of abuse made against the Maguires. We do not accept Anton Skinner's position that this was necessary to get the Maguires to leave Blanche Pierre.

<u>The fostering of WN81</u>

9.459 When Jane and Alan Maguire left Blanche Pierre they fostered one of the children from the FGH, WN81. On 14 November 1990, David Castledine (Fostering Officer) noted that Anton Skinner requested him to carry out an assessment of the Maguires as foster parents, albeit this had "*already been agreed by senior staff".*[423]

9.460 On 27 November 1990, Richard Davenport (WN81's CCO) noted that he explained to the Maguires that a fostering assessment would have to take

[423] WD004634

place.[424] A memo from him, also dated 27 November 1990, noted that he visited the Maguires but that registration "*has not involved a fostering assessment*".[425]

9.461 Between 27 and 29 November 1990, an application was completed that noted, under the heading "Social Work Assessment" that the transfer and registration was agreed and approved by Anton Skinner and senior staff.[426] The Foster Parent registration permit is dated 13 December 1990,[427] as is the police check.[428]On 18 December, the transfer of WN81 to the Maguires as foster parents is recorded along with a note that a supervising officer is necessary in accordance with policy and the law. Richard Davenport says that it should not be him.[429]

9.462 In evidence to the Inquiry, David Castledine said that he was not aware of any allegations against the Maguires until after the fostering of WN81. He found it difficult to answer the question as to whether he asked why the Maguires had left Blanche Pierre. He was specifically asked to carry out the assessment of the Maguires and this was the only time where the referral came directly from Anton Skinner. He was puzzled as to why he was chosen, as Anton Skinner would have known that he would want to go through the formal process and carry out a full review. When he interviewed them as part of the fostering process he said that they were uncomfortable with his questions. His concerns were significant enough for him to raise the matter with Anton Skinner. He felt that he was presented with a fait accompli. It did not occur to him to take his concerns to the Education Committee. He said that the final decision on fostering was made by Anton Skinner.[430]

9.463 Anton Skinner gave evidence at about the decision to foster WN81 with the Maguires.[431] He said that WN81 had lived with the Maguires since she was a baby and the SCCOs (Brenda Chappell and Ann Herrod) put forward a

[424] WD004638
[425] WD004639
[426] WD004640
[427] WD004635
[428] WD001105
[429] WD004630
[430] WS000609; Day 85/97
[431] WS00064; WS000734/9; Day 88/170

strong case for the fostering – he said that the impetus came from them. Notwithstanding Anton Skinner's knowledge of the Maguires' abusive behaviour towards the children in their care, he believed that they had a unique relationship with WN81. Anton Skinner said that this was not a decision negotiated with the Maguires but one based upon the view of child care staff.

9.464 In his witness statement Anton Skinner said that at the time he thought that the "*inappropriate behaviour*" of the Maguires had been mainly directed at one particular boy and *"there was no suggestion that this was mirrored with any of the other children".* In evidence to the Inquiry he said that he was not aware of WN81 being mistreated. Anton Skinner was taken to his own record, dated 27 April 1990, of his interview with Susan Doyle and Karen O'Hara[432] which recorded WN81 having been punished for wearing the wrong dress. He retracted his assertion that there was no suggestion that the behaviour "*was mirrored with any of the other children".*

9.465 Anton Skinner was asked whether he took into account the allegations against the Maguires when he made the decision to foster WN81. He replied that he *"took account solely of the proposals that were put to him as to the effect on this child if she was not placed with the Maguires".* He was aware of the general assessment procedure for fostering but formal procedures were not needed, said Anton Skinner, because they were dealing with a *"de facto fostering situation of some years*". The decision to involve the Fostering Officer, David Castledine, was an administrative decision. Anton Skinner could not recall whether he informed David Castledine of the Maguires' background but would find it *"astonishing*" if David Castledine had not been aware of the situation. Although he would usually accept David Castledine's advice on any concerns, in the case of WN81 the decision had already been made at a senior level that it was in her interests to foster her with the Maguires. Anton Skinner did not recall David Castledine asking him to provide reasons why the assessment procedure was not carried out.

[432] WD007092/1–2

9.466 Anton Skinner knew that the foster relationship broke down after 18 months. When presented with documents relating to the breakdown of the relationship he said that it came to a "*very sad end*" for reasons that did not lie with the actions of the Maguires. The documents included a record of a meeting, facilitated by Children's Services, between WN81 and Jane Maguire. Jane Maguire was asked a series of questions by WN81 and her answers were recorded by the CCO. They were questions WN81 "*always wanted to ask Jane*". Jane Maguire was asked by WN81: "*Do you still love me – can we still be friends?"* and Jane Maguire answered: *"No*".[433]

9.467 Dorothy Inglis told the Inquiry[434] that CCOs queried the appropriateness of fostering a child with the Maguires given the circumstances. She said there was "*almost disbelief that that would be a course of action that would be taken".*

9.468 Audrey Mills said that she was not consulted about the fostering. Although she thought that it should not have happened she did not tell anyone at the time: *"I was kind of taken along with it because she had been with them from a baby."*[435]

9.469 **Finding:** In our view, the decision to allow WN81 to be fostered by the Maguires following their departure from Blanche Pierre was an inadequate response to disclosures of abuse. Normal procedures were circumvented and Anton Skinner instructed David Castledine, the Fostering Officer, not to undertake the requisite fostering assessment of Janet and Alan Maguire. For whatever reasons, WN81 was placed with two individuals who were known by the Education Department to be unsuitable to care for children. This was a dereliction of duty and we are not surprised that the fostering decision was met with incredulity by others within the Department at the time.

Children's Services' involvement in response to allegations (1990–1998)

9.470 Marnie Baudains (CCO in 1990) told the Inquiry that there was, at the time, a sense of unease about the Maguires "*that something bad had happened*".

[433] WD001059; WD001058
[434] Day 97/107
[435] Day 73/47

She was not aware of specific incidents of assault. Asked what she would have done, as a senior manager, on receipt of Dorothy Inglis's report in 1990 she replied:

> *" … it would have been wise to have conducted a child protection investigation. Even if that had not led to prosecution … the team was very much in its infancy but I imagine that every young person would have been interviewed".*

9.471 Audrey Mills managed Blanche Pierre between 1990 and 1993 at which point the FGH was closed. She said in her statement to the Inquiry that when she moved to the Home "*the children would tell me how the Maguires used to call them stupid and generally belittle them … the thing that struck me most … was their use of the phrase 'we cannot do this' or 'we're not allowed'".*[436]

9.472 In May 1997, Alan Maguire contacted the police concerned about a threatening letter that he had received. A former resident at Blanche Pierre, WN76, was interviewed by the police and disclosed that she had been physically and sexually assaulted as a child by Alan and Jane Maguire. In her statement to the Inquiry, Audrey Mills said that about this time in 1997, WN76 disclosed to her that she had been sexually abused by Alan Maguire.[437]

9.473 Marnie Baudains first became involved in the Maguires' case in May 1997, when she was Manager of the Children's Services CPT. She contacted Assistant Inspector Barry Faudemer to report suspected child abuse on the part of Jane and Alan Maguire. Barry Faudemer wrote a memo to the CPT requesting a formal investigation into Jane and Alan Maguire. The memo notes that "*The Children's Office have harboured suspicions about Mr and Mrs Maguire for some considerable time, but no children have come forward to make definite complaints of abuse".*

It concludes:

[436] WS000585
[437] WD005444

> *"The Children's Office believe that there is a strong possibility that a significant volume of abuse will be unearthed during the course of this Inquiry".*[438]

9.474 Marnie Baudains told the Inquiry that the children had been failed by Children's Services: "*I think the fact that we did not discover all that had happened to these young people meant that it's quite likely that we did not provide them with an appropriate level of care and therapeutic support that they could have benefited from in the years following the Maguires' departure."*

9.475 Marnie Baudains confirmed that in 1997 those who had lived with the Maguires were identified and a search was conducted for case records. Furthermore, the police had "*all the diaries*" (i.e. from Blanche Pierre) for their investigation.

9.476 In her 2008 statement to the SOJP, Linda MacLennan (former CCO) provided an account of disclosures to her by WN76 and how Linda MacLennan dealt with this. She told the police: "*On a professional level I had no doubt what WN76 was telling me was true, at times she tried to play it down, she did not seem to have a reason for telling me things other than she just seemed to have the need to talk about these events in her life. She did however stress her dismay at how Jane Maguire was being allowed to still work with children within Social Services on the island*". Linda MacLennan went on to describe the action that she then took on receiving the disclosure: "*As a result of what WN76 was telling me I instigated contact with child protection team and this included the Police who began an investigation … as soon as WN76 began to tell me this I told her we should not talk about it further and that a proper investigative interview should take place. This was done but I was not present when it took place and because of procedures we did not discuss it between us afterwards*". Linda MacLennan states that she felt, as did WN76, that there had been a cover up, "*I had concerns over the way certain things with Jersey Health Care Services* [sic] *had been handled. There appeared to be a culture of sweeping things under the carpet*".

[438] WD006281

9.477 Following the police investigation, the Maguires were charged and brought to an "old-style committal hearing". Karen O'Hara gave evidence at the committal hearing in June 1998,[439] as well as giving a police statement, which concluded: "*I find it really difficult to verbalise the humiliation and degradation that these children suffered. It was a constant tirade of eroding their most basic rights, like contact with their extended families … I am very angry, still, at what I experienced and how the children were treated even after the Maguires left."*

9.478 Susan Doyle gave a statement to the police in 1997,[440] which included the following extracts:

> *"It is difficult to set down on paper the emotional abuse which these children suffered … they lived under a regime of day-to-day fear of the couple.*
>
> *"The children were constantly demoralised and threatened, sometimes with removal to Heathfield. I remember when* [WN154] *had run away, Alan and Jane were shouting at her that she was a slapper like her mother and always had her knickers up and down, like her mother. This was in the presence of Richard Davenport who was the children's Child Care Officer ...*
>
> *Brenda Chappell was in charge of the group homes, but she was great friends with Jane and Alan and there was no way we could speak to her."*

Susan Doyle gave evidence to similar effect at the committal hearing in June 1998.[441]

9.479 A neighbour of the Maguires also gave evidence at the committal hearing and provided a detailed account of mistreatment that she witnessed:

> *"I feel that I have let all these children down. I know from what they have told me and what I have seen that these children have suffered appallingly. These kids confided in us, but we did not know who to report this to. We also felt that the kids would be in even worse trouble if he got back that we'd reported what was happening."*[442]

[439] WD000602
[440] WS000547
[441] WD000209
[442] WD006351; WD006352

9.480 WN307 worked at Blanche Pierre from 1980 to 1989 and gave a statement to the police. She said that she never witnessed any violence and the children never complained.[443]

9.481 Richard Davenport (CCO) said in his police statement:[444]

"I certainly did not have any concerns at the time that the children have been subjected to any abuse by Alan and Jane Maguire."

9.482 Statements were also taken from three former residents who said that they had been happy with the Maguires. One left Blanche Pierre in 1984, another in 1985 and the third in 1987. They were all in their late teens at the time of their departure.[445]

9.483 As noted elsewhere, the case against the Maguires was dropped following the committal proceedings. A meeting was held to discuss the decision at which Marnie Baudains was present, although she did not recall the details in evidence to the Inquiry.[446] The contemporaneous file note[447] records that Marnie Baudains said that it would be "*extremely difficult for the victims"* if the case was dropped, and would damage their faith in the system. Picking up on the phrase used by Advocate Binnington (Crown Prosecutor), she expressed the view that "*if public interest was the test, the public interest lay in bringing a prosecution".* The AG, Michael Birt, explained that public interest only came into effect where there was sufficient evidence, and any decision would be based on the evidence rather than the public interest. With regard to the decision taken not to proceed, it was noted that: "*No-one dissented from this view although naturally there was sadness that this decision had to be taken."*

9.484 **Finding:** The response of Children's Services to the disclosures of abuse in 1997–1998 was adequate. Marnie Baudains and Linda MacLennan, among others, responded appropriately following disclosures, and a multi-agency

[443] WD005476; WD005477
[444] WD000579
[445] WD000576; WD000577; WD000580
[446] Day 91/117
[447] WD007098/75–76

investigation was instigated. The decision to drop the case was taken by the AG.

The disciplinary investigation (1999)

9.485 When the Maguires' prosecution was abandoned in 1998, Graham Jennings, Chief Executive, HSSD, decided to embark upon a disciplinary process against Jane Maguire. He told the Inquiry: " … *it was clear to me from the evidence that I had seen that there was very likely a case to answer in terms of professional misconduct and that was the reason I asked for the report.*"[448]

9.486 Dylan Southern, Head of Mental Health Services, was asked to carry out a review and produce a report as to whether there was a disciplinary case against Jane Maguire. Dylan Southern interviewed, among others, Dorothy Inglis, Anton Skinner, and Jane Maguire. He was unable to speak to Brenda Chappell but did interview a number of former residents of Blanche Pierre. He was given access to all the police papers, including the home diaries. In his statement to the Inquiry he described his feeling of "*absolute horror*" reading the diaries and he told the Inquiry he could not understand why a "*visiting professional did not just look at the diaries".*[449] He said: *"[Jane Maguire's] actions were clearly inappropriate, cruel and openly recorded and available in the home. In my view, her behaviour constituted gross misconduct on numerous accounts at the very least."*[450]

9.487 Dylan Southern interviewed Jane Maguire and a record of that interview is exhibited to his statement.[451] Jane Maguire had no recollection of the meeting with Anton Skinner on 30 April 1990 nor of the allegations made by Susan Doyle and Karen O'Hara. She denied the allegation that she washed the children's mouths out with soap. Dylan Southern told the Inquiry that he took Jane Maguire through the diary entries: "*my recall is that there was no response … She was very quiet about it*".[452]

[448] Day 138/122; WS000715
[449] Day 116; WS000677; WD008663
[450] Day 116/30
[451] WD008663/13
[452] Day 116/65

9.488 He also told the Inquiry that during his interview with Anton Skinner he showed Anton Skinner, for the first time, extracts from the diaries. Asked about Anton Skinner's reaction he said: "*muted would be the best way of describing it*".

9.489 In his statement to the Inquiry, Dylan Southern said:

> *"For the purposes of my investigation, drawing a distinction between the two sets of allegations was irrelevant and bore no consequences to the ultimate conclusion, which was that there was incontrovertible evidence, fully available in previous years and at the time in 1990, that Jane Maguire was reported as abusing the children in her care. That, to me, was all the evidence that was needed in order for Children's Services to take action; and for the children to have been immediately protected from Jane Maguire and her husband. Her employment status was secondary to the needs and protection of the children concerned. She should have faced a full investigation, which initially should have been led by the police and her employment in tandem or following a police decision on any action to be taken."*[453]

9.490 Two versions of Dylan Southern's report were available to the Inquiry, one being 10 pages longer than the other. Each report however has an identical concluding section and recommendation:

> *"There is sufficient evidence to show from the police, and my own investigation, that Ms Jane Maguire, whilst employed as the Housemother at Blanche Pierre Group Home:*
>
> *(a) Clearly understood her role and responsibilities towards the children in her care.*
>
> *(b) Understood that a policy existed which forbade the use of corporal punishment on the children in her care.*
>
> *(c) Breached this policy by inflicting, allowing and condoning physical punishments.*
>
> *(d) Inflicted, allowed and condoned various forms of severe physical abuse on the children in her care.*
>
> *(e) Inflicted, allowed and condoned psychological abuse on the children in her care.*
>
> *(f) Is guilty of numerous offences which constitute gross misconduct.*

[453] WS000677/17

> *I recommend that Miss Jane Maguire is dismissed from the employ of the Health and Social Services Committee."*[454]

9.491 Dylan Southern told the Inquiry that he removed passages from his original draft on his own initiative. He removed a passage that referred to Mrs Maguire's "*gross disregard for the psychological well-being of children when she chooses*" as it referred specifically to her treatment of a girl at the Home. He also removed an entire section which was a critique of the actions of Children's Services at the time. This included references to staff saying that they had been approached by Anton Skinner not to say anything, the fact that the CPT had not been involved in 1990, and that the children had not been interviewed by their CCO. His remit, he explained, was specifically to consider whether there was a disciplinary case against Jane Maguire. Dylan Southern, in evidence, denied that he was asked to remove these passages by Graham Jennings or that he had professional issues with Anton Skinner. Dylan Southern sent Graham Jennings a copy of the revised report under cover of a letter dated 23 February 1999 recommending Jane Maguire's dismissal.[455]

9.492 Dylan Southern told the Inquiry that he wrote a second letter to Graham Jennings on the same date (23 February 1999) suggesting that Anton Skinner's conduct should be reviewed by an independent senior peer group – he added in evidence to the Inquiry "*my personal view is that he was absolutely responsible*". In his statement to the Inquiry, Dylan Southern said:

> *"… I believe the most senior and responsible officer within Children's Services failed those children miserably and Jane Maguire has never been held to account".*[456]

9.493 Dylan Southern received no response from Graham Jennings to the second letter. No such letter has been obtained by the Inquiry.

9.494 In his evidence to the Inquiry[457] Graham Jennings said that his memory of the draft report was that it was at his insistence that the references to Children's Services be removed. The draft report was too broad and should

[454] WD008663/24
[455] WD009305/75
[456] WS000677/24
[457] Day 138/127

specifically address Jane Maguire. He said: *"I took on board his criticisms, at least in part, and addressed them with Anton Skinner after the disciplinary hearing*". He could not recall receiving a letter from Dylan Southern regarding Anton Skinner. He said that whether or not he received the letter he understood Dylan Southern's concerns and followed them up with Anton Skinner. Graham Jennings felt that Anton Skinner had taken steps to protect the children. He acknowledged that Anton Skinner should have considered disciplinary action against Jane Maguire in 1990 and that he should have spoken to the children.

9.495 Graham Jennings told the Inquiry that he "*struggled*" to understand the letter signed by Iris Le Feuvre in 1990 (the "110% letter", as it became known).

9.496 He was invited by Counsel to consider alternative options open to Anton Skinner that would "have been preferable to handling the situation in a way that did not recognise the abuse that was alleged". He replied:

> *"I think that the evidence in 1999 was really very, very damning and I think it was very difficult for anybody to deny or defend. There was hand written records of their own making in terms of the things that were going on with the children at that time, and, you know, it appeared a really brutal regime. It had no place in the care of children, what was happening in that home and in 1999 that was patently obvious."*[458]

9.497 Graham Jennings said that, in his judgement, nothing he had found out about the events of 1990 had called into question Anton Skinner's professional competence in 1999, saying: "*No – I have not seen anything … which made me question either his integrity, his commitment to the service or the people he was offering the service to".*[459]

9.498 Upon receipt of the Dylan Southern report, Graham Jennings wrote to Jane Maguire on 10 March 1999 to convene a disciplinary hearing on 22 April 1999. Graham Jennings wrote to Jane Maguire after that hearing: "*the panel recommends your dismissal".*[460] Jane Maguire tendered her resignation

[458] Day 138/138
[459] Day 138
[460] WD009305/156

before the recommendation was put to Committee. It was accepted by Graham Jennings.[461]

9.499 In his supplementary statement to the Inquiry, Anton Skinner said that Dylan Southern's view of the position in 1990 represents a

> *"total misunderstanding of the position as presented in 1990 … I believe that a re-examination of their [Dylan Southern and Barry Faudemer] evidence shows that they are responding to my actions in 1990 from a perspective of what was known in 1998 and what was suspected by no one in 1990 – not by Susan Doyle or by Karen O'Hara or Brenda Chappell or Richard Davenport or by anyone else involved with the Maguires and the running of the Group Home".*
>
> *"I can categorically state that there was no cover-up. I dealt with a very complex situation to the best of my abilities and with only the welfare and best interests of the children uppermost in my mind."*[462]

9.500 Anton Skinner also criticised Dylan Southern's evidence as "*full of inaccuracies and omissions".* He said that he was unaware of the existence of the Blanche Pierre diaries until the disciplinary investigation in 1998/1999. He had no recollection of an informal meeting with Dorothy Inglis, David Dallain, Richard Davenport and David Taylor where concern was expressed about Jane Maguire's redeployment in Children's Services.

9.501 **Findings:** In carrying out the investigation into Jane Maguire, the response of the HSSD in 1999 was adequate. Dylan Southern wrote a clear and measured report and we reject the criticisms levelled at Dylan Southern by Anton Skinner. There was "*incontrovertible evidence*" at the time in 1990 that Jane Maguire was reported as abusing the children in her care. Her employment status should have been secondary to the protection of the children in her care. Dylan Southern concluded, and we agree, that in 1990 she "*should have faced a full investigation*" led by the police. The question of her employment should have been examined in tandem or following the conclusion of any police investigation.

9.502 Despite Dylan Southern's identification in 1999 of failings on the part of Children's Services, and particularly Anton Skinner, in 1990, no action was

[461] WD009305
[462] WS000734

taken in response. We find that this was inadequate. Whether or not a letter was sent or received relating to Anton Skinner's conduct, by failing to investigate, Children's Services absolved themselves of responsibility in relation to the failures in 1990. Anton Skinner's conduct showed, at the very least, an absence of judgment and professional skill.

The involvement of Children's Services (2008–2009)

9.503 The Maguire case was revived in 2008 and legal advice sought from different counsel. Various former and current staff members from Children's Services gave statements to the SOJP. The case, which is dealt with in more detail under in Chapter 11, was not pursued and Alan Maguire died in 2009.

9.504 Anton Skinner was interviewed by the police in 2008.[463] He said that he considered the FGH a "*flawed model*" given the stresses and strains on the Housemother. "*In a sense the Education Committee were culpable in all of these group homes in setting up impossible situations*". He expressed the view:

> *"I believed that nine tenths of the complaint could be summarised as old-fashioned parenting in an attempt to cajole the children into doing what they wanted them to do. That would not have been seen as offences probably to this day … the one incident that may have warranted referral to the police was pushing the child so the child fell across the playroom … that was subject to considerable disagreement between Ms Doyle and Mr Maguire as to what the true extent of that push was and I believe in the sum total of all of that if I'd given the report to the police at the time … said what I intended to do, the police would have said that's correct if that's what you want to do."*

Les Chênes/Greenfields

General staff evidence

9.505 A number of members of staff at Les Chênes said that they never saw any abuse by staff of residents or the use of excessive force on anyone.

[463] WD006255/3

9.506 A medical professional who visited residents in the late 1980s and early 1990s did not recall witnessing any type of abuse or inappropriate behaviour by staff towards children and none was ever reported to him.[464]

9.507 WN834 said in her statement to the Inquiry that any complaint about the actions of a member of staff would be investigated by her: "*I have no recollection of any real incident of concern about the behaviour of any member of staff. I did not experience anything that led me to question the behaviour of any member of staff during the entire time of being employed at Les Chênes."* WN834 had regular access to an external adviser if she was concerned about any issue in the school that she did not wish to discuss *"internally"*.[465] She could not recall any allegation of abuse being made against a member of staff although "*pupils would complain if they perceived an injustice".*

9.508 WN834 did remember dealing with an allegation that an older boy had tried to touch a younger boy's genitals in the shower. She says that she was called to Mario Lundy's office to hear the complaint and to ensure that a written record existed before Mario Lundy asked the older boy about the allegations. The Social Workers of both boys were contacted. A risk assessment was carried out and a plan put into place. WN834 remembers undertaking work with the older boy "*about his sexuality and inappropriate physical contact*".

9.509 One member of staff remembers another member of staff pouring a jug of milk over WN628's head. No complaint was made by WN628 at the time. The incident was recorded and reported to the principal.[466]

9.510 A number of staff members who worked at Les Chênes/Greenfields in different capacities and in different decades gave evidence that they did not witness anything inappropriate or any violent behaviour against residents.[467]

[464] WD006126
[465] WS000719
[466] WD006151; see WD006137 for variation of account – reported and no action taken
[467] WD006125; WD006127; WD006128; WD006130; WD006132; WD006135; WD006136; WD006138; WD006139; WD006140; WD006143; WD006144; WD006145; WD006146; WD006147; WD006149; WD006150; WD006154; WD006155; WD006165; WD005847; WD006866; WD006873

9.511 There do not appear to be any allegations relating to abusive treatment at Les Chênes in the 1990s, with one exception.

Individuals accused of abuse

9.512 We are only able to make findings as to the response to allegations of abuse where there is contemporaneous evidence of disclosure.

WN108

9.513 WN108 said that the allegations made against him were totally alien to his overall philosophy and his approach to his work. In his 40 years of teaching he had never assaulted a child: "*I would not want people to think that a culture of abuse pervaded Les Chênes as that was absolutely not the case.*"[468]

9.514 He told the Inquiry that no complaints of assault had been made against him while he was at Les Chênes.

9.515 He gave the following evidence to the Inquiry[469]

- He never assaulted a child.
- He denied the suggestion that he was a teacher with a physical approach but accepted that he may have poked a child in the chest when addressing him or her.
- He accepted that he did challenge WN622 and explained the circumstances as he remembered them: "*The individual made a move to attack the member of staff … I restrained the child, we both fell to the floor, but I certainly did not punch him, I certainly did not kick him. In all my years of working in education I've never been involved in such an intervention. It would be totally alien to the whole of my philosophy on working with young children.*"[470]
- He described one office that had built in furniture (suggesting that it could not have been moved) and that if he had pushed the child around the room

[468] WS000597/4
[469] Day 79
[470] Day 79

(described by witnesses as "pin-balling") it would have destroyed a relationship with the child and would have been counter-intuitive to what they were trying to achieve at Les Chênes.

- He recalled the circumstances surrounding one allegation that he punched a child in the face and stamped on the child's legs. He said that the young person stole something from a staff member and tried to attack that person. He therefore had to restrain that young person but did not use excessive force. He had not punched him in the face or stamped on him. He told the Inquiry that, at the time, "*There was no formal guidance or formal policy on the use of restraint*".[471]
- He had *"absolutely no recollection*" of pushing WN622 against a wall for using the word "*abortion*". WN622's allegation that he pushed him through a dining hatch and kicked him after WN622 threatened WN246 with a knife was "*totally unfounded*" and "*physically impossible*".[472]
- He could not remember WN622 being caned for having a "wet tissue fight" and if such a fight occurred it would not have resulted in caning. If WN622 had punched another boy that may well have resulted in corporal punishment.
- He never picked a child up by the ears.
- WN145 was not kept in solitary for six weeks – "*that never happened*".[473] WN145 may have slept in secure for six weeks but "*certainly would not have been kept there under lock and key for such a long time*".[474]
- The incident described by WN145 of being pushed against the wall of a room, jabbed in the chest and thrown to the floor never happened.[475] Given the dimensions of the room that was physically impossible.
- He had no memory of WN591 coming to see him about being hit by a member of staff.

[471] Day 79/8
[472] Day 79/22
[473] Day 79/26
[474] WS000597/4 – records suggest that he did sleep in secure for six weeks due to renovation works at the premises
[475] Day 79/31

Mario Lundy

9.516 Mario Lundy addressed the allegations made against him in his evidence to the Inquiry.[476] His response to allegations made against him during his time at HDLG are contained in the section above relating to HDLG (1970–1986).

9.517 Mario Lundy attended a voluntary interview with the SOJP on 2 December 2008 and 2 December 2009 "*to answer questions in relation to Operation Rectangle*". He denied all of the allegations put to him. He distinguished between those that were "*complete falsities*" and those that were "*gross exaggerations*". He explained: "*If I was accused of punching somebody it might well have been that I restrained them but then it was taken a step further and I make no bones about it. The fact of the matter is that if I felt at the time that there was no option and the young person needed to be restrained because of their behaviour, then I would have taken that action.*"[477]

9.518 His evidence to the Inquiry about the allegations made against him while at Les Chênes was as follows:

- All the allegations against him related to the period 1982–1985, save for one.
- He had not heard the expression "pin balled" until interviewed by the police in 2008. In response to WN179's allegation that Mario Lundy had 'pin-balled' WN620[478] Mario Lundy simply said: *"No."* He had never broken a resident's bones.
- The allegations that he made a boy put aftershave on his groin after he had shaved off his pubic hair was "*absolutely preposterous*".
- He could not remember an incident, described by WN623, that he had grabbed hold of WN620 by the side of the neck and dragged him out of sight. It is possible that if there had been an incident on a football pitch, he may have taken hold of somebody and taken them away to calm them down but not in the way that has been alleged.

[476] Day 74/203 onwards
[477] Day 74/205
[478] See Chapter 8, Les Chênes – WN620's account

- He denied WN651's allegation that he slapped him across the face, swearing and shouting and then pushed him against a safe. Mario Lundy said he had never slapped someone across the face and there was no safe on the premises. He did not witness an assault by WN108.
- He denied WN80's allegation that he hit him on the back of the head with his knuckles, causing him to fall forwards. Mario Lundy did not remember this and denied that he then went on to "*drag*" WN80 to the secure room where he remained naked for four or five days.
- He said that there was no "*tacit*" agreement with WN108 they would punish the children together.
- In response to the allegation that he and other staff members had dragged a child out of the day room and the child was not then seen for two weeks, Mario Lundy replied: *"No. There is almost a perception being developed here of an institution that operated in a vacuum. There were Probation Officers just about every week who joined in activities with the young people. They went surfing with their charges. Somebody would have noticed if a person was taken out of circulation for two weeks. That's just absolutely false.*"[479]
- He denied throwing WN591 out of bed with the words "*I've been waiting for ages, I've had your name on a locker here".*
- In response to the allegation that Darren Picot was taken down heavily by Mario Lundy during a game of rugby and who then stamped on his head, back, arms and legs, Mario Lundy replied that this did not happen. He did not tackle roughly when he played rugby with residents as he was conscious that he was playing with young people.
- He denied Darren Picot's allegation that he would often slap or push him down the stairs: "*That just didn't happen."*[480]

9.519 Mario Lundy summarised, in evidence to the Inquiry, his response to the allegations: *"There are twenty-seven allegations from, I think, around twelve or thirteen young people. In the whole of my teaching career, and I have*

[479] Day 74/220
[480] Day 74/224

dealt with thousands of young people, I have not had a single spontaneous complaint against me … ".[481]

9.520 In answer to questions from the Panel, Mario Lundy reflected: *"I think I had a physical presence and I wasn't intimidated.*" He dealt with the more physical episodes, particularly if female teachers were involved, as he felt it was his responsibility: "*I didn't shy away from it, but I didn't at any time feel that I was doing anything that was malicious towards a young person, but trying rather to do something that would bring them under control.*"[482]

9.521 Monique Webb said that she never saw a child come out of staff offices in distress. Jonathan Chinn said that no child complained to him about being hit by Mario Lundy and he never heard him referred to as the "pin ball wizard". He had never seen Mario Lundy hit a child.

WN245

9.522 In 2001, WN761 was admitted on remand and made threats against another resident. WN245 and another staff member tried to speak to him. "*He just exploded with rage"* and the decision was taken "*to get him into a cell – he ended up in the cell, but we were both injured in the process*". He described the restraint used: "*We basically had to push him and then shut the door.*"[483]

9.523 WN761 made an allegation of assault against WN543 and WN245 to the SOJP after having absconded and told his mother. He had also raised concerns about the staff treatment of a fellow resident, who was his girlfriend. This was in the context of WN245 and WN543 alleging that WN761 had assaulted them. WN245 and WN543 denied assaulting WN761.

9.524 During an SOJP investigation into this complaint,[484] they also considered the possibility of more widespread abuse, as well as the possibility that Les Chênes staff (including WN245 and WN543) had conspired to provide false information to the investigating officers. The matter was investigated by

[481] Day 74/203
[482] Day 74/254
[483] Day 75/106
[484] WD008106/1–15

SOJP officers unconnected with the FPT, in order to avoid unnecessary damage to their relationships with Les Chênes and the Children's Services.

9.525 The decision taken was that it was not in the public interest to pursue the case against WN761, the resident. WN245 said to the Inquiry: "*We were left with no assurance that we had acted correctly.*"[485]

9.526 The conclusion of the SOJP report was that an "*urgent and thorough*" review of the policies and practice at Les Chênes, with a particular focus on the use of secure rooms and restraint was needed. It was noted that Tom McKeon, as Director of Education, had undertaken to instigate such a review as soon as possible. They particularly asked for consideration of the facilities, the need for appropriate legislation, the need for training, the need for complete and accurate records, the need for frequent and ongoing monitoring of the remand facility, and the need for procedures to allow "inmates" to report any concerns about their treatment to an independent monitoring body. We are aware that in fact, this led the Director of Education to commission the first report by Dr Kathie Bull. [486]

9.527 WN245's responses to the other allegations against him are as follows:

- In a police interview in 2009, WN245 denied stripping WN628 leaving him naked in a cell for six hours. He recalled WN628 taking off his own clothing down to his boxer shorts and threatening to harm himself. He and another staff member just left WN628; it was not true that WN628 was two months in isolation.
- WN245 had no memory of seeing WN627 held in a headlock. "*I've never seen that at all.*"[487]
- He did recall an incident concerning WN631 when he used restraint, following TCI techniques, but only after he and others had tried to talk to him. He did not pull out WN631's hair. [488]

[485] WS000592/2
[486] WD004264/23–24; Day 113/71–3; WS000652/24–25; WS000591/20
[487] Day 75/110
[488] Day 75/111

- He did not forcibly use a headlock to get WN630 into a car to take him back to Les Chênes. He did not hold WN630's neck "*bent back over the rear seat of the car*" during the return journey.[489]
- WN245 told the police it was possible that he jabbed WN632 in the chest but not in the throat. He had conceded to the police that this approach "*might not be appropriate*".[490] He told the Inquiry: "*ten or fifteen years ago things were looked at in a slightly different way. So, like all of us, we've made mistakes, but I do not think I've acted maliciously in* [sic] *any occasion*".[491]
- WN52's allegations that WN245 grabbed him, pulled his shirt over his head, punched him in the stomach and kicked him as he fell to the floor was "*complete fabrication*".[492]
- WN245 contacted the police following a telephone call made to him in which the caller alleged WN245 had touched a young person's penis. The police interviewed the caller, who admitted it was false.[493]
- WN245 said he had never seen a headlock being used at Les Chênes.[494]

9.528 **Finding:** Following the detailed SOJP investigation in 2001 and the request for an urgent review of policies and procedures at Les Chênes, the Director of Education commissioned an inspection by Dr Kathie Bull. The SOJP's assessment of the matters needing attention at Les Chênes was insightful. This commissioning of an inspection was an adequate response to concerns raised by the SOJP. However, as reflected in the criticisms made by the SOJP in their report, this response was, by then, too late.

WN543

9.529 WN543 told the Inquiry, in relation to WN629's allegation that he witnessed an assault by WN543 on a boy: "*To the best of my knowledge that incident never happened.*"[495] WN629 also described him holding a resident up

[489] Day 75/112
[490] WD006418/6
[491] Day 75/114
[492] Day 75/115
[493] Day 75/117
[494] Day 75/123
[495] Day 77/164

against the wall by his throat. WN543 told the Inquiry: "*That is absolutely not true.*"

9.530 WN543 gave his account of the incident that involved both WN629 and WN698: *"So we were looking to admit the young people, but they just did want to be there, you know. They'd come in, they were still agitated, they were still fairly angry and one of these young people actually did attack me … I called for another member of staff to come and help. I took one of the young people down to the secure area with another member of staff."* A medical report, exhibited to WN543's statement, describes the injuries he received during the incident.[496] He told the Inquiry that he did not assault WN629 or WN698.

9.531 As set out in Chapter 8, following this incident, WN629 disclosed to WN543 that she and WN698 had been the victims of rape. This was reported to police the next day.[497]

9.532 WN543 gave his account to the Inquiry of the incident described by WN698. He remembers there being a number of other people present "*including a probation officer and other members of staff*". He opened the door but did not "*at any time kick her in the stomach. That is complete fabrication*". He gave a statement to the police in 2003 in which he described kicking the door down and his actions thereafter. In the same statement, he referred to techniques that he had been taught on a four-day course.[498] Asked whether WN698's medical report at the time was consistent with the use of restraint techniques, he told the Inquiry those around him would have intervened if he had used "*undue force".*

9.533 Following this investigation by the SOJP, we have not seen any evidence of any consideration of an internal investigation into WN543's conduct, despite the fact that the SOJP report [499] found that there was a possibility that the "*petechial haemorrhage to* [WN698's] *eyelids was caused during the restraint".* It was noted that if this was the case "*it would have been due to*

[496] WD006485/13
[497] WD003976
[498] WD006485/26
[499] WD005115

the restraint technique being applied inappropriately in some manner". The report concluded that there was no evidence that WN543 acted other than appropriately given the situation and there was no substance in the complaint of assault made against him. However, it also said that "*It might be advantageous for the education department to review this case and ensure that their staff are fully aware of the risks involved in applying extended periods of restraint. There will be situations such as this case when it is necessary to restrain violent young people while awaiting assistance. The risks involving acute behavioural disturbance and positional asphyxia must be understood in these situations".*

9.534 Exhibited to WN543's statement are short descriptive notes provided by the police in relation to the allegations made against WN543 and his response at the time of the police interview in 2009. He told the Inquiry that all the allegations arose out of the late period of Les Chênes after 2000.[500]

9.535 WN543 was invited to respond to an allegation relating to an incident in March 2009.[501] He gave a detailed account to the Inquiry[502] of his visit, with a colleague, to a young person's family home. The young person started to attack his mother and was restrained until he calmed down. He then grabbed a knife and threatened them with it. WN543 called the police.

9.536 WN543 was invited to respond to an incident recorded in March 2010 of him "*grabbing and pushing*" an individual. He provided a detailed account to the Inquiry of his involvement in this incident.[503]

9.537 One member of the teaching staff (2004) described WN543 as a "*bully and a horrible person due to his treatment of staff and children*".[504] Another witness recalled watching him using restraint and thinking that he had gone "*over the top*".[505]

[500] WD006485/47
[501] WD006471
[502] Day 77/186
[503] Day 77/189
[504] WD006147/2
[505] WD003973

9.538 **Findings:** In 2002, a complaint by WN629 of being raped by someone outside of the School was made to WN543. This was in the context of an altercation in which WN543 had himself been physically assaulted. The fact that this was reported to the SOJP the following day was an adequate response.

9.539 We have not seen any evidence to suggest that the Education Department did review the 2003 case in which an allegation of assault against WN543 was made, despite the recommendation from the SOJP. The inability to take steps to learn lessons was an inadequate response to this allegation.

WN246

9.540 WN246 accepted, in evidence to the Inquiry, that, in retrospect, his drinking must have had an impact on his ability to care for the residents at Les Chênes.[506] His response to the allegations made against him was:

- He did not prod WN620 in the chest, pushing to the floor and straddle him, holding his jaw, while still on the ground.
- He did not pour a bowl of chocolate mousse over the head of WN179, in front of other residents.[507]
- He did crash a car while driving three residents home from school but the accident did not happen because he had been drinking. He told the Principal immediately on return to Les Chênes, the police were called and no further action was taken.[508]
- He denied WN621's allegation that he deducted points under the MAS for her not eating her food – food was never used under the system: it was a right.[509]
- He denied WN621's allegation that he had punched a resident in the face in a classroom and that when the resident got up from the floor pushed him into another classroom. He told the Inquiry that had he done so the Principal would have found out, given the small scale of the school.[510]

[506] Day 93/189
[507] Day 93/190
[508] Day 93/192
[509] Day 93/193
[510] Day 93/194

- He denied WN621's allegation that he grabbed her by the hair and also her allegation that he had had a fight with a resident in the kitchen. He said he was not a violent person. It was not something that he would have done.[511]
- He had no recollection whatsoever of WN621's allegation that he dragged a resident to the toilets and threw him against the wall while holding onto his sweatshirt. WN246 said that he had no recollection of this "*whatsoever*". He said he sought to avoid confrontation.[512]
- WN145 alleged that on two occasions WN246 threw him around first the woodwork room and on the second occasion the art room. WN145 alleged that WN246 was often drunk on duty. WN246 replied that he could not recall these incidents and he would not have gone to work if he thought he was drunk, although "*I would have had a drink some time, before I went to work*".[513]
- He did not force a child to eat food to which they were allergic, making them sick. WN246 said that he would not have used food in this way to punish a child. He viewed the MAS as a way of sanctioning children.[514]
- He could not remember parents coming to the school to complain about his treatment of their son.
- He denied punching a child in the shower room. "*The child I meant to have attacked said I did no*t".[515] WN246 told the Inquiry that he had not punched the same boy in the head in the laundry room.
- He could not recall assaulting a child in the canteen, throwing him over a sofa and grabbing him in a headlock. *"It's not the way I deal with things*", he said in evidence.[516]
- WN246 accepted in evidence that if Tom McKeon said that he had seen him forcibly push a child against the wall and had spoken to him, then it must be true. He could not remember the incident.[517]

[511] Day 93/198
[512] Day 93/197
[513] Day 93/202
[514] Day 93/205
[515] Day 93/203
[516] Day 93/208
[517] Day 93/209

9.541 Monique Webb remembered that WN246 would have a lot of run-ins with the children. She thought him a bit harsh with the MAS and recalled that he rarely gave children points. She recalled WN246 grabbing a child and pushing him against the wall and thought at the time that this was "*a bit over the top*". She may have been wrong that it was him but he did have "a short fuse" but she never had concerns about the children.[518] She did remember him being on duty, smelling drink on his breath and reporting it. It was only in the evening on activities.[519] She had reported her concerns to the Principal when WN246 was driving a school vehicle and she smelled drink on his breath.[520] WN246 maintained that he would not have been driving had he been drunk but "*I am sure that I have driven it having had a drink*".[521]

9.542 Peter Waggott worked with WN246 but was not aware that he had any issues with drink. He never saw him lose control and did not agree WN246 had a short fuse: "*He was known as a strict member of staff and he was a bit of stickler for the Merit Award System.*"[522]

9.543 Tom McKeon had had to reprimand WN246 when he saw him push a child against a wall. He sent the boy back to the classroom and then spoke to WN246. He took no disciplinary action, aside from warning WN246. As already referred to, Tom McKeon did not think that this amounted to gross misconduct.[523] He was aware of the drinking problems but this was not the cause of the accident with the school vehicle. WN246 had taken "avoiding action" at the time. He learnt of the incident sometime after it happened and then warned WN246.[524]

9.544 Mario Lundy issued WN246 with a formal reprimand in May 1993, for drinking before coming on duty.

[518] Day 70/67
[519] Day 70
[520] WS000577
[521] Day 93/191
[522] Day 93/191
[523] Day 77/73
[524] Day 77/127

9.545 In 1997, WN109 wrote to Tom McKeon, as Director of Education, detailing WN246 coming to work having been drinking.[525]

9.546 In evidence to the Inquiry[526] Tom McKeon said that he sent WN246 home on two occasions when he had been drinking and undertook his duties himself. On the second occasion he told him that if there was a recurrence that he would seek dismissal. When asked whether sufficient steps were taken to protect the children he said: "*It could be argued that [WN246] should have been removed immediately … my view was that he had many good qualities … and was going through a difficult time in his life so needed to be supported as well as disciplined."*

9.547 WN246 for a time worked with Kevin Mansell. In that time Kevin Mansell saw no evidence of WN246 working having been drinking. He told the Inquiry that WN246 was "*without doubt the strictest person on the staff but I cannot think of an example where he overstepped the mark … he was very strict on the implementation of the rules which existed … he was prepared to spend hours doing [the activity] with the young people which they really enjoyed".* Kevin Mansell described WN246 as knowing exactly how far to go but then stop.[527]

9.548 **Finding:** We consider that failing properly to deal with WN246's alcohol problem represented a significant failure of management. No-one caring for children who reports for duty, having been drinking, should be dealt with by way of a warning. Whatever sympathy there may have been for WN246, he should not have remained in post while his drinking was a problem. Any member of staff on duty under the influence of alcohol poses an unacceptable risk to the children in his or her care.

WN110

9.549 In his evidence to the Inquiry, WN110 gave the following responses to allegations made against him:

[525] WD005976
[526] Day 77/79
[527] Day 80/11

- He could not remember pushing WN620 over the edge of a sofa[528] and could not remember an alleged incident when he pushed WN641 *"clear over*" a couch: "*It just would not have happened.*"[529]
- He could remember the incident in relation to WN627 in 2002. He had had to restrain him by using a bear hug and both ended up on the floor. He had not shouted at WN627: "*the sorts of students we deal with they have had lots of teachers shouting at them at previous schools and that does not really work and so I found shouting to be a waste of time".* He had not kept WN627 in a headlock for an hour: *"I must've been very strong*". Another staff member, WN655, witnessed the episode. "*There was no shouting. WN110 was using all the techniques in attempting to calm WN627 down*". She went on to describe how WN110 did not use any "*inappropriate behaviour whatsoever".*[530]
- WN110 remembered that restraint training was introduced when Les Chênes became Greenfields at which point the teaching staff were not involved in restraint. Complaints about the use of restraint, "*this would have been the care staff who would have been involved with this*".[531]
- A child kept in isolation continually for two weeks: "*This would not happen*". He could not recall anyone coming out of isolation appearing "*in any way to be physically injured*".[532]

WN110 told the Inquiry that "*I do not think that I ever lost my temper*". He did not remember kicking a person in the legs in a rugby game causing him to fall to the ground. He could not remember having punched a pupil in the head while he was playing goal keeper.

Another member of staff at Les Chênes remembers working alongside WN110 when they were trying to calm WN653 down. He remembers that WN110 "*took hold of WN653 and restrained him as he was screaming and shouting obscenities. I went ahead of WN110 and WN653 opening doors in order that WN110 could convey WN653 into secure. The manoeuvre lasted*

[528] Day 72/12
[529] Day 72/16
[530] WD003961
[531] Day 72/23
[532] Day 72/225

15 seconds in all. The next step would have been to inform Kevin Mansell or Peter Waggott of the incident and the 'occurrence book' would have been endorsed accordingly".[533]

WN544

9.550 In response to the allegations made against him, WN544 gave the following evidence to the SOJP in interview:

- The allegation that he punched WN630 was "*completely untrue*". He never punched a student "*ever*".[534]
- WN544 was alleged to have hit a resident's head on a table and then "*dragged*" him to secure, hitting his head against the wall as he went. WN544 remembered taking the resident out of class but without any violence taking place. He took him to the Deputy Principal's office to cool down. The account given by WN627 did not happen.
- He recalled having to restrain WN630 and WN73 to stop them escaping after they smashed a window using a pool ball wrapped in a sock and threatened the staff with table legs. He told the police who attended that the situation was "*very rare indeed*".[535]
- WN544 was "*very conscious of the dangers in dealing with female children as a male member of staff and team leader*". He denied the allegation that he watched WN698 and WN629 changing in their room and refused to leave when they asked him to do so. He had never been in that room without a female staff member present.[536]
- He denied that he ever stamped hard on the toes of one resident in the football yard, saying that this had never happened.

WN654

9.551 WN654 was employed as a part-time care worker at Les Chênes, working occasional shifts during the evenings and at weekends.

[533] WD003980
[534] WD003986
[535] WD003986
[536] WD003972

9.552 Allegations of abuse were made against him in 2003 and subsequently similar allegations were made during Operation Rectangle. WN73 disclosed to WN687 in 2003 his concerns regarding the treatment of the children. The allegations against WN654 referred to striking a child on the head, grabbing/restraining another child by the testicles and restraining the same child, banging his head on the floor. There was a further allegation that WN654 exposed himself in the shower room.

9.553 WN687 reported the matter to Phil Dennett who in turn forwarded the complaints to the FPT, via Sarah Brace of Children's Services. It was noted that "*the police and Children's Service know all the alleged victims in this Inquiry … they are all troubled young men and regular offenders at Les Chênes*".[537]

9.554 WN654 gave the following account when interviewed by the police:

- Regarding the alleged striking of a child in the head, he said that he was struck on the mouth by the child's elbow and tried to push the child away but believed he had caught the child on the bridge of the nose and forehead. He denied striking the child twice to the head or threatening to hurt him "*badly*".
- He denied restraining a child and banging his head on the floor when in the secure area.
- He denied being deliberately naked in front of a child; he said he turned his back when a resident walked in so as not to expose himself.
- Regarding the alleged grabbing of WN630's testicles he told the police that he decided to restrain WN630 to prevent him attacking another pupil: "*I tried talking to* [the child] *to come back into secure, he swore profusely at me and then it was a case of how do we get this guy back into secure before an incident of violence happens, so I made a decision there and then. I got hold of [the child's] hand, his right hand. Pulled his right hand down put my left hand between his legs from the back got hold of* [the child's] *hand and surprised him by pulling him downwards so* [he] *was now bent double with me holding his hand behind him, saying come on … back in into secure,*

[537] WD005740/3

let's go. He was swearing profusely at me and calling me a queer because I had pressure on his testicles however I did explain to him there and then that if he bent forward it was not my hand on his testicles it was his own arm. So if he bent forwards and walked forward we'll go back into secure and everything will be fine, if you stand up it will put more pressure on you and we do not want that so come on lets just go into secure". WN654 said that he did not record the incident in the log at the time because *"it did not merit it, it was not in my opinion a major incident up until now*".

9.555 Another care worker witnessed the incident and told the police that having been trained in restraint what he saw WN654 doing was not a legitimate restraint technique. WN776, a full-time care worker, witnessed WN654 grab WN630 by the testicles and told him to put the child down immediately. The incident, it appears, was not recorded.

9.556 In 2003, DC Brian Carter carried out a police investigation into complaints by residents about the use of restraint by staff, including the episode between WN654 and WN630 (see Chapter 10). He prepared a 15-page report.[538] No prosecutions followed. The investigation prompted a memo from DS Beghin to DI Bonney in which reference is made to procedural problems "within Les Chênes" to be addressed with Phil Dennett.[539] Phil Dennett was invited to comment about the police memo and what his involvement was. He told the inquiry that the reference to him was mistaken as the HSSD had yet to take over the running of Les Chênes at this date. Had it been his remit he told the inquiry: "*If a member of staff for whom I had responsibility had acted in the manner described I believe I would have instigated an internal investigation to establish whether disciplinary action was necessary."*[540] There was no evidence before the Inquiry as to what action was taken, if any, by the Education Committee, WN654's employer.

9.557 **Finding:** The episode between WN630 and WN654 was a serious incident in which, on one view, the use of restraint had been allowed to go beyond

[538] WD008662/417
[539] WD008662/433
[540] Day 134/24

what was reasonable. We find that there should have been an internal investigation carried out by the Education Department. In the absence of any evidence of such an investigation, we conclude that one did not take place. The Department must have known or at the very least should have known about the police involvement. By 2003, such an internal investigation would have followed recognised procedure and practice. We view this as a serious failing. WN654's actions were never subject to internal review.

Aviemore

9.558 In May 2003, allegations were made about a residential CCO's care of children at Aviemore, including allegations about physical chastisement. A disciplinary meeting was convened by Danny Wherry,[541] who wrote a report into the allegations that was passed to senior management. The allegations included allowing a child with severe learning difficulties to walk without shoes for a mile; shutting a child outside for refusing to eat dinner; and slapping of a child on the thigh. The report, written in June 2003,[542] concluded that the member of staff disregarded the personal safety of children and staff and suggested that the matter be dealt with under the gross misconduct procedure. It was noted that staff had all expressed anxiety about whistleblowing.

9.559 No finding is made about this case, because we do not have documents relating to the final action taken in this case.

9.560 In 2002, allegations were made by a former resident at Aviemore, WN4, that he had been sexually assaulted in the 1990s by WN518, a former member of staff there. A substantial investigation was completed by the SOJP and a decision was made that there was insufficient evidence to prosecute.[543] At this time, WN518 was working for Social Security, although the allegations related to a time during which he was employed by the HSSD. The employment situation was considered and a letter (dated October 2004) from Inspector Bonjour of the SOJP stated that "*I am able to say from my*

[541] WD009350
[542] WD009343
[543] WD004825

knowledge gained during my review of this matter that there are no other circumstances I am aware of that give me cause for concern".[544]

9.561 The allegations were reviewed during Operation Rectangle in 2008, following concerns raised by WN4's parents, although no new evidence was provided. A decision was again made not to proceed and no action was taken in respect of his employment at this stage.

9.562 In 2013, allegations were raised by another former resident of Aviemore about WN518. A timeline regarding the concerns raised about WN518 was produced while the investigation was ongoing.[545] In June 2013, WN518 was arrested and the allegations put to him, which he denied. A meeting was held in July 2013 about these concerns under the SOJP/States of Jersey "Memorandum of Understanding" (MOU), in which it was noted[546] that he had access to vulnerable adults during the course of his employment and that this was a serious allegation. It was concluded that in light of the seriousness of the allegation, WN518 should be suspended.

9.563 A subsequent meeting was held in October 2013,[547] in which it was noted that there was insufficient evidence to proceed against WN518, however a public interest disclosure had been made. It was noted that there was no evidence of the complaint being malicious, nor that there had been collusion between the complainants, whose time at Aviemore did not overlap. A decision was taken approximately a week later to lift WN518's suspension.[548]

9.564 **Finding:** In our view, the response of the HSSD to both allegations made against WN518 was adequate. Both disclosures of abuse led to investigations by the SOJP, and on both occasions the Department considered the employment position of WN518 and whether there were any risks. This was in accordance with the policy and procedure of the day.

[544] WD008597
[545] WD009200
[546] WD008597
[547] WD008595
[548] WD008596

Response to allegations against CCOs

9.565 Allegations of abuse, and failure to respond to abuse by CCOs, have, for the most part, been dealt with elsewhere in the Report, with the exception of the following:

Richard Davenport

9.566 Linda MacLennan, in her statement to the police in 2008,[549] recalled that when she first started as a CCO (approximately 1983), she was approached by a former resident at HDLG. WN213 told her that Richard Davenport sexually assaulted her when she was at the Home. Linda MacLennan knew that she had to report this disclosure " … *So I followed procedure and prepared a written report about what WN213 had told me*". She submitted the report to Ann Herod, her SCCO, who told her that it would be dealt with. Linda MacLennan received no feedback. "*Richard Davenport was still working as a Child Care Officer when I left Jersey (in about 2003)".* Although there is reference by Linda MacLennan to following procedure, the procedure that was laid down is not set out in the report.

9.567 The SOJP subsequently followed up Linda MacLennan's account. Richard Davenport's personnel file contained no reference to Ms MacLennan's written report. The police report[550] details further allegations made against Richard Davenport, concluding: "*There is no record of any kind of complaint or discipline record on Davenport's file.*"

9.568 In 2009, a seven-page police report was compiled bringing together, in one document, allegations made by children in care that Richard Davenport had failed to act on complaints that they made to him about being abused.

9.569 Richard Davenport provided a statement to the police in 2009, relating to the allegation that WN167 disclosed to him sexual assault by WN743 while in foster care. She maintained that Richard Davenport, her CCO at the time, told her that she was to put that time behind her and he would ensure that

[549] WD005449
[550] WD006872

the family would not foster any more children. Richard Davenport denied that this ever happened: "*I would have been outraged at such an allegation, recorded it in detail … And it would have gone through the system to the line manager*". He said: "*My conscience is clear professionally.*"[551]

WN7

9.570 In 2001, an allegation was made by a mother that WN7 aggressively manhandled her son, who was the subject of a care order. A three-page report was prepared, detailing the investigation carried out by Sarah Brace, a Children's Services Team Manager. The report concluded that the allegation had little foundation and that no further action was required. The mother was told of the outcome and advised that if she wanted to take it further she should put her concerns in writing to Phil Dennett.[552]

9.571 In 2003, PS Barrot prepared a report for the FPT. It detailed an account of a child taken to La Preference in a police car and refusing to get out of the car. WN7's assistance was sought and he is described as arriving on the scene and proceeding to "*drag [the child] out of the car by her arm. This caused her great distress … ".* WN7 provided a detailed response.[553] He said that he told her "*in a directive manner that she was to get out of the car … She was unable to do so due to still having a seatbelt on. She leant back and undid her seatbelt and then slid along the seat. I did not 'drag' her. The first physical contact I had with her was as she was going to the ground on exiting the car. I held onto her arm stating words to the effect 'Stand-up' … It became obvious that she was 'going to ground' and therefore I let her go*".[554]

Hal Coomer

9.572 Hal Coomer was a CCO from 1975 until 1990. WN341 alleged that he told Hal Coomer that he had been sexually abused. Another complainant, WN132, said that Hal Coomer arranged a video interview after WN132 alleged that he had been abused in a ward at the general hospital. When

[551] WD006859
[552] WD006837
[553] WD006840
[554] WD006840

asked about these two complaints in 2008, Hal Coomer told the police that he could not remember WN132 or WN341. If such allegations had been made, he said that he would have done something about them.[555] In a later statement he did recall both individuals but still denied the allegations.[556]

WN766

9.573 WN766 was a CCO from 1982 until 2002. In April 1988, following a visit by him to a family home, a six-year-old child made an allegation that he indecently assaulted her. The allegation was reported to the SOJP by the child's mother. A police investigation included an interview with the six-year-old and her brother. The police report, completed nine days after the complaint, concluded that the assault had not occurred and that "*there should be no slur on the character of [WN766]*".[557]

9.574 The Children's Section received the police report a week later, and Anton Skinner wrote to DCI Le Brocq:

> *"As we agreed, the allegation and the problems encountered during the investigation highlighted the need to equip officers from both agencies with the specialist skills necessary to cope with this sensitive and complex area of our work … I would hope we could set up a local training course … within the near future … I look forward to a new chapter of expertise and co-operative progress in this challenging area of work."*[558]

9.575 A review five years later, by SCCO Ann Herrod, highlighted that WN766, at the time of the investigation, felt that "*he did not receive adequate support or counselling*" and noted that "*the after-effects of the allegations need further discussion and they are inhibiting progress*".[559]

9.576 **Findings:** With regard to the Department's response to allegations of abuse against CCOs, we note that such allegations were generally investigated, by the SOJP where necessary. There is a lack of clarity regarding the allegations about Richard Davenport: the evidence of Linda MacLennan was

[555] WD006863
[556] WD006862
[557] WD006827
[558] WD006827
[559] WD006824

that she prepared a written report regarding an allegation of sexual assault in the 1980s, but no such report has been seen by the Inquiry.

Fostering services

1950s

9.577 Winifred Lockhart disclosed alleged physical abuse and neglect from her foster mother, WN961, to a visitor from the "Social Welfare Department". According to Winifred Lockhart, this resulted in WN961 stopping the physical chastisement but she carried on depriving her of drinks. Winifred Lockhart was eventually moved from her foster home when she was sent to school with chickenpox and the headmaster intervened.[560] This is confirmed by contemporaneous records.[561] She was sent to the JHFG under the Poor Law provisions.[562]

9.578 **Finding:** The relevant Department did respond to a report of physical abuse and neglect in foster care in the 1950s – in the case of Winifred Lockhart, action was taken by a visitor and she was eventually removed from the Home.

9.579 WN964 and WN963 were fostered by WN965 and WN962. WN964 said that she was a "*slave*" for her foster parents, getting up early every morning to work before school. Both she and her sister were regularly beaten by WN962 with a belt, brush or stick. She said that the school, neighbours and the Parish Constable knew what was happening as both girls told people how the bruises had been caused. Nothing was done about it. In 2008, WN964 told the police that WN962 would keep the girls under lock and key and would tie them to a chair when she went out. She said that WN965 used these occasions to offer them money to touch their breasts. They were never forced to do anything to him.[563] In 2008, WN963 confirmed the alleged

[560] Day 11/36
[561] WD000010/5
[562] Day 11/38
[563] WD006594

abuse to the police and indicated that the Constable of St Helier knew of the alleged abuse.[564]

9.580 Michael Laing was fostered by Nancy Elson and in evidence to the Inquiry, made allegations of physical abuse during his time there. He also alleged that WN969, Nancy Elson's son, sexually abused him while he was living in the foster home.[565] Michael Laing did not report the alleged abuse by Nancy Elson and WN969 because he tried to "*block out*" the abuse.

9.581 Nancy Elson gave a statement to the Inquiry in September 2014,[566] but has since passed away. She said that she treated Michael in the same way as her own son – she would slap them on the hand or back of the legs if they were in the wrong. She considered there was a difference between slapping and hitting and does not recall hitting Michael. She would never embarrass the children by complaining or grumbling about them in front of others. She denied that Michael was beaten two or three times a week and thought it was much less frequent than that. She could remember beating Michael for helping an old lady carry firewood upstairs, or beating him with a spoon. She also denied having gagged Michael while he was being beaten.

9.582 WN341 was resident at HDLG in the 1960s – at the weekends, he stayed with foster parents along with his brother. WN341 alleged physical and sexual abuse against both of them. WN341 said that he told a number of people about the abuse at the time. Jim Thomson would not listen. He told the Head of Children's Services who "*did not want to know*". He told a CCO called [Hal] Coomer and Patricia Thornton who he said knew the couple well. He also told Ms Bygraves *"who was lovely when I told her and she said she was going to help me*".[567] He was eventually stopped from staying with his foster parents. There are no contemporaneous records of any disclosures or response.

9.583 WN174 was fostered by WN483 as a single parent from 1958 to 1967. He alleged physical abuse and neglect. Someone contacted the authorities and

[564] WD006595
[565] Day 9/89
[566] WS000533
[567] WS000242/6

he was moved to HDLG. The alleged abuse is documented in the contemporaneous records. One record described WN483's "*strange ideas about bringing up children*", suggesting that Children's Services were aware of the physical abuse of WN174. Another record indicates that notwithstanding reports of being tied to a banister, having his head held underwater and being thrashed with a stick, he showed a surprising amount of affection towards WN483.[568] At the time WN483 cared for WN174, she was looking after a total of eight children. In a case conference in 1967, Colin Tilbrook expressed concern about the situation in WN483's foster home, given that so many of the children were getting into trouble.[569]

9.584 A note from Colin Tilbrook in July 1969[570] said that returning WN174 to the care of WN483 would be "*a regression and would be absolutely wrong for him".* Nonetheless WN174 decided he wanted to live with WN483 again and returned to her care in October 1970.[571] There is no record of any formal action in response to the allegations made against WN483 by WN174. There is no record of the allegations being put to her.

9.585 **Finding:** In the 1960s, according to the accounts of witnesses and the small amount of contemporaneous records, some action was taken in response to allegations of abuse by children in foster care. Both WN341 and WN174 were removed from their foster parents after disclosing abuse. However, the response of the Department to return WN174 to his foster mother, despite significant allegations of physical abuse, was inadequate according to the standards of the time. We agree with Colin Tilbrook's expressed view at the time – it was "***absolutely wrong"***, despite WN174's own wish to return.

<u>Death of a child in private foster care</u>

9.586 In December 1978, a year-old child who was being privately fostered died in hospital after being shaken by his foster mother, Mrs Le Moignan, who was sentenced to four years in prison for manslaughter.[572] In July 1979, a report

[568] Day 35/34
[569] WD001271/112
[570] WD001264
[571] WD001257
[572] WD006510/9

into the death of the child was produced by the Director of Education (then John Rodhouse) and the Medical Officer of Health (MOH), which was published in full by the JEP. When he was asked about this report in his evidence to the Inquiry John Rodhouse could remember very little save that the report was commissioned by the Presidents of the Health and Education Committees, and that the case and report attracted a good deal of press attention at the time.[573] The narrative that we have gleaned about this case is largely based on the findings of the report.[574]

9.587 The child had been privately fostered in April 1978 along with his sister, initially without the Education Committee being informed, despite the legal requirement to do so. By September 1978, the Children's Office became aware of the placement and of the fact that neighbours had complained about the treatment of the children.

9.588 In discussions between David Castledine (the CCO) and the Health Visitor, arrangements had been made for close supervision. This amounted to a visit by David Castledine every three weeks (although in fact he visited more), set against the usual pattern of visiting a child in private foster care once every three or four months.

9.589 A chronology records complaints about the care of the children being made on 19 September 1978, 13 October 1978, 24 October 1978 and 3 November 1978. David Castledine and the Health Visitor were fully aware of police investigations carried out the previous year into bruises sustained by a girl who had been privately fostered by the same couple.

9.590 Although David Castledine had ready access to and consulted Anton Skinner, SCCO at the time, about the case, no analytical review was done to establish the options open to the Children's Service and it was assumed that nothing could be done unless there was positive and incontrovertible evidence of ill treatment.

[573] Day 95/197
[574] WD006509

9.591 The report concluded that "if the Children's Office-had held wider powers to prohibit fostering by 'unsuitable' people"; and "*if there had been in the Island an effective body with power to co-ordinate and direct the actions of all the various agencies that exist to protect children at risk; then it could have been possible to remove the [ ] children from Mrs Le Moignan's care before the tragedy occurred"*.

9.592 A recommendation was made that a Children's Review Committee be established to deal specifically with allegations of non-accidental injury before they reached the point of police investigation. Another recommendation was that no distinction be made in the supervision of foster children in the care of the Education Committee and those in private foster care.

9.593 The report concluded that David Castledine (and the Health Visitor) did all that they could and more than could be reasonably expected.

9.594 In evidence to the Inquiry about the case, David Castledine said[575] that a weakness in the *1969 Law* was that Children's Services were not aware of all of the private fostering going on in Jersey – in this case it was only discovered by the Health Visitor, who brought him in as CCO to the children. He said that the obligation to visit private foster homes was quite limited and was not a priority for CCOs given their caseload, although he acknowledged that perhaps it should have been and said that they changed their policies thereafter.

9.595 David Castledine said that they were aware of rumours about the care provided by the foster parents, including concern raised by a teacher, but nothing substantial emerged and there were no bruises etc. They had nothing to act on and the only power of intervention was an increased level of contact: the children were visited 17 times in three months.

9.596 In response to the part of the evidence which referred to physical mistreatment of the children,[576] David Castledine stated that his

[575] WS000609 and Day 85/67
[576] WD006760/152

understanding was that there was one anonymous phone call. He was also aware that the foster parents had previously fostered and the police had been involved in investigating complaints about bruises sustained, but nothing was found.

9.597 David Castledine said that following the death of the death of the child, changes were made to ensure that private foster arrangements were reported to Children's Service. He said that the recommendation of setting up a Children's Review Committee was not adopted, although he thinks that the Director of Education, the CS-C and the Children's Office requested amendments to the *1969 Law*.

9.598 He did not think that the recommendation about not distinguishing between boarded-out children and private foster children in terms of supervision ever came into fruition, and the registration process for the former continued to be more thorough. He also could not recall a body being set up to co-ordinate and direct the actions of all of the various agencies on the island.

9.599 **Findings:** The response to complaints made about the care of the young child being privately fostered by Mrs Le Moignan was adequate. There was multi-agency involvement and an increased level of contact following the complaints. A subsequent report concluded that David Castledine and the Health Visitor did all that they could and more.

9.600 However, there were some failings at a higher level. There was an erroneous assumption that nothing could be done about the complaints unless there was positive and incontrovertible evidence of ill treatment, and there was no high-level analytical review.

9.601 The distinction at that time between the supervision of children in private foster care and those who had been boarded out was problematic. The failure to correct this distinction following a recommendation to do so was an inadequate response. Compounding that failure, as noted above, in 1979, Charles Smith is recorded as commenting in the press that the Children's Department have a "*minimal role to play"* in private fostering and simply had to ensure that "*physical standards"* were satisfactory, with none of the

"*stringent procedure"* that was in place for those boarded out.[577] Their duty under the *1969 Law* was to "*satisfy themselves as to the well-being of the children".*

9.602 The initial response to the death of the child was adequate: a comprehensive report was prepared by the Director of Education and the MOH to investigate what had happened and make recommendations for the future.

9.603 However, the response to this report was inadequate and few lessons appear to have been learned. This would have been an ideal opportunity to introduce a "Children's Review Committee" that would have been able to address allegations of non-accidental injury before they reached the point of police investigation. This would have put Jersey in an excellent position to respond to allegations of abuse over the next decade and more. The failure to establish such a Committee at the time was a lost opportunity.

WN99

9.604 WN99 was fostered in the early 1980s. He alleged abuse at HDLG but said that the foster family was not much better as he was forced to work for them despite the fact that he attended school. On one occasion, after a beating from the foster father, he said that he ran away to his mother's house. She called the CCO Richard Davenport. According to WN99, he was sent straight back to the foster home without the complaints having been taken seriously.[578] There are no contemporaneous records of this report.

WN803

9.605 WN803 made allegations of physical and sexual abuse against her foster father[579] who became her adoptive father in 1981.[580] The allegations are supported by her sister WN901. WN803 described making a video recorded statement at Children's Services at some point after the age of 11 (i.e. after 1988). Her foster mother took both girls to Children's Services, but WN803

[577] WD004611
[578] Day 45/67
[579] WS000689
[580] WS000705

does not recall what, if any, action was taken.[581] WN901, her sister, made the same allegations against the foster/adoptive father. She recalled the police being called after he beat her when she was seven years old. She said that she and her sister were taken to their uncle's house.[582] WN901 said:

> *"I feel that my fostering and subsequent adoption was neglectful on the basis that [the foster father] had a known alcohol problem. I feel he was allowed to adopt us because he was a policeman and because of this, proper checks were never completed."*

9.606 WN803 made a written submission to the Inquiry:

> *" … when you're adopted … you already feel like you're not good enough, when you're given to new parents, you expect them to be vetted and you expect to have reports of abuse followed up".*[583]

9.607 There are no contemporaneous records of the statement made by WN803 to Children's Services.

9.608 **Finding:** If WN803 made a statement to Children's Services in the late 1980s/early 1990s and this was not acted upon, that is to be deprecated. However, in the absence of contemporaneous records of such a disclosure (particularly when other disclosures of that time are recorded), we cannot come to a finding on this matter.

WN857

9.609 As discussed in Chapter 10, in 1991, a 13-year-old girl disclosed that she had been indecently assaulted by her foster father WN857, leading to an investigation by the SOJP and a decision not to prosecute.

9.610 A report was subsequently written about the case in August 1991 by Marnie Baudains, which noted the breakdown of the placement and the fact that the complainant's family's representative had been told about the allegations.[584]

[581] WS000689/2
[582] WS000705/2
[583] WS000689/2
[584] WD008600

9.611 **Finding:** The response of the Education Department to allegations of sexual abuse made against WN857 was adequate. The foster parents' registration was removed, the disclosure was passed to the SOJP for investigation, and a follow-up report was written after the decision not to prosecute.

WN858 and WN859

9.612 In 1994, allegations of physical abuse were made against WN858 and WN859, the foster parents of a two-year-old child. The multi-agency response, involving an investigation by Children's Services and the SOJP, with the input of Dr Henry Spratt, is set out in Chapter 10 (paragraph 10.90).

9.613 **Findings:** The Education Department's response to allegations of physical abuse against WN858 and WN859 was mixed. The fact that the child and another foster child were removed from the foster parents at an early stage in the investigation suggest a procedure that put the immediate interests of the child first. The removal of the foster parents' registration following the investigation was also appropriate, as was the debriefing session carried out which included lessons to be learned.

9.614 We note that a multi-agency approach was taken to the investigation of this case, with Children's Services initially investigating to see whether there were any concerns about non-accidental injuries, and then requesting the involvement of the police once such concerns were established. However, the SOJP later noted that in the absence of "*immediate and full liaison between the Children's Service and the police"*, the inquiry had been made more difficult and had taken longer.

9.615 Further, we find that there were failings on the part of Children's Services in their response to this case:

- Initial concerns about bruises, raised by the child's mothers, were dispelled on the basis of the bond between child and foster mother – this was not an adequate response.
- The CCO described the foster parents as having provided "*excellent care"* through the placement, despite having to speak to them about physical punishment of the child and despite this incident. This description was

inappropriate given the injuries inflicted by the foster parents, which were known to the CCO.

- It was not appropriate for the Child Protection Case Conference to make a recommendation that the foster parents should not be prosecuted. This was not part of their role and may have unreasonably influenced the decision about whether to prosecute this case.

WN860 and WN861

9.616 Later the same year, allegations of physical abuse were reported against WN860 and WN861, following injuries identified in a 19-month-old girl who was being fostered by them. The investigations carried out by the SOJP and by Children's Services' CPT[585] are discussed in Chapter 10 (paragraph 10.102).

9.617 **Finding:** The initial response of the Education Department to the allegations of physical abuse against WN860 and WN862 was adequate. A multi-agency investigation was carried out, in which the CPT produced a report, which included consultation with paediatricians, concluding that injuries appeared consistent with having been carried out inadvertently by their young child. However, no Child Protection Conference was held to ensure that measures were in place to protect the child, which we consider to have been inadequate according to the standards of the time.

WN862

9.618 As discussed in Chapter 10 (paragraph 10.107), concerns were raised on various occasions from 1995 onwards that WN863, a registered foster parent, had committed sexual offences against his previous foster daughter, WN974. Several of these disclosures were made to those working within the HSSD.

9.619 **Findings:** In our view, on numerous occasions, the HSSD failed to respond adequately to concerns raised about sexual abuse perpetrated by a registered foster parent, WN862:

[585] See report at WD006617

- In 1995, a disclosure of sexual abuse from a relative led to a report from the CCO. This concluded that there were no grounds to investigate further, partly on the basis of a denial from the alleged victim, as well as positive reports about the foster parents over the years. This was an inadequate response.
- Disclosures in 1997 and 1998 from WN964, the alleged victim, led to a case conference being held and a multi-agency response. This initial response was adequate. The investigation led to a confirmed disclosure from WN964, but she said she didn't want to make a formal complaint. The file was sent back to Children's Services, but no action appears to have been taken. WN862 remained as a registered foster parent, with no further action taken. This was inadequate.
- Further disclosures were made in 1999, in February 2000 and in October 2000 – however no action was taken to remove WN862 as a foster parent. In 2001, Tony Le Sueur "*expressed criticism of previous investigations"* and recorded his decision not to place any further children with WN862. He noted that once the children currently in their care came "of age" in 2003, they would be deregistered as foster parents. During a strategy meeting in 2005, it was noted that the allegations had never been investigated by Children's Services. We are concerned that although this showed the Department finally grappling with the issue, they were sufficiently concerned about the allegations to deregister the foster parents, but not to remove the children in their care at the time for over a year. We consider that the response continued to be inadequate.
- An adequate investigation was carried out in 2005/2006, involving Children's Services and the SOJP. By this point, WN862 was no longer a registered foster parent and the main issue from the perspective of Children's Services was the protection of WN964's own children, who had ongoing contact with WN862. The investigation was hampered by the refusal of WN974 to co-operate, but included the identification of others who had been fostered by WN862.

WN812 and WN813 – allegations about their son, WN884

9.620 Chapter 10 sets out the response of Children's Services, as well as the SOJP, to allegations of abuse made by children in foster care against the son of their foster parents, WN884.

9.621 WN812, the foster mother, told the Inquiry[586] that she had initially thought that the allegations were untrue. She complained that Children's Services did not provide support when they needed it most, during the investigation. She said that she and WN813 made the decision that they could not continue to be foster parents and ripped her licence into pieces, although they did continue to look after one girl in a private arrangement. She acknowledged that this was at the same time as they were told by Children's Services that they were going to be de-registered.

9.622 **Findings:** In our view, the response of the HSSD to these allegations was adequate. The response to the disclosures was swift, and involved strategy meetings with the SOJP, suspension of the foster parents, alternative placements of the children in their care, and an investigation into the files of all children who had been fostered by WN812 and WN813. Following the SOJP investigation, the foster parents were deregistered because of the risks posed by their son.

A private foster father (2003)

9.623 In September 2003, a 15-year-old child in private foster care disclosed to her CCO that she had been indecently assaulted by her foster father. The fostering was a private arrangement between the two families which was supported by Children's Services, who had conducted a private foster assessment, along with carrying out police checks and taking a reference from a family friend. The disclosure was passed to the SOJP FPT.[587] Following an admission by the foster father, in December 2003, the foster father was convicted of one count of indecent assault and sentenced to two

[586] WS000681/78, 13, 14
[587] WD006628

and a half years' imprisonment.[588] His name is not given, in order to protect the identity of the victim.

9.624 A "recommendation to close" document was completed in February 2004,[589] which noted that in advance of the placement an initial private fostering assessment had been completed, along with application forms, references, police check and home visits. It was further noted that the foster father should "*clearly not be able to care for any other young person in the future. A warning should be placed on the 'softbox' programme regarding his schedule one status".*

9.625 **Finding:** The response of the HSSD to this disclosure of abuse was adequate. The matter was passed to the SOJP, and an investigation led to successful prosecution. Following this, Children's Services ensured that their system reflected that the perpetrator should not be able to care for other young people in the future.

WN865

9.626 As noted in Chapter 10 (paragraph 10.157), a disclosure of indecent assault by a 14-year-old in foster care led to the conviction of her foster mother's fiancé for indecent assault. Consequently, the Fostering Panel considered the continued placement of the child.

9.627 **Finding:** On the basis of the limited evidence, the response of the HSSD to this case was adequate. Although the foster mother was not implicated in the allegations, a detailed report was produced about her continued suitability, taking into account past concerns about relationships and what the situation would be in the immediate future. We consider that this was appropriate in the circumstances.

[588] WD006627
[589] WD009199

CHAPTER 10

The Response by the States of Jersey Police to Concerns of Abuse

10.1 In analysing the Police response under Term of Reference 11, it is necessary to consider the structure and development of the States of Jersey Police (SOJP), in particular with reference to Operation Rectangle and to the action taken where abuse was suspected.

The States of Jersey Police: background

10.2 The SOJP is a professional Police service with paid officers and staff. The Chief Officer is accountable to the Minister for Home Affairs.

10.3 Graham Power was the Deputy Chief Constable of Lothian and Borders Police and a member of HM Inspectorate of Constabulary, Scotland, before his appointment as Chief Officer of the SOJP in 2000.

10.4 Graham Power recognised in the early days of his tenure the need for a specialist senior CID officer. The President of the Home Affairs Committee resolved that the appointee must come from outside Jersey. This inevitably generated some resentment but nonetheless Lenny Harper, an officer who had served with the Metropolitan Police, Royal Ulster Constabulary and Strathclyde Police, was appointed Chief Superintendent and Deputy Chief Officer (DCO) designate. He was appointed Deputy Chief Officer in 2003.

10.5 Graham Power's evidence was that he had told the appointments board that Lenny Harper was an uncompromising man who would be a bold choice for the SOJP; he would "rattle cages" and would be relentless on ethical issues.[1] Lenny Harper told the Inquiry:

> *" … People who found me abrasive were those who were breaking the rules and who were bullying or doing other things. For every one that found me abrasive I have letters and emails from people who appreciated me being abrasive with people who were causing them*

[1] WS000536/11

> *severe problems. As for – I could never have carried out the job that Graham Power was doing. My forte was operational Police work and investigations and I would not have been happy doing the Chief Officer role and it was never ever my wish to take on that role."*[2]

10.6 Graham Power identified as an inevitable aspect of island policing the fact that everyone knew everyone else. It was often necessary to take disciplinary action that could have been avoided in a larger Police service; in a large service, an officer at fault could be transferred to a distant station for a fresh start, something that was not possible in Jersey. On the other hand, there was a huge advantage, he told the Inquiry, in having officers policing the community in which they lived; the officers were motivated by their knowledge that their service affected their own community, and officers picked up local knowledge; these factors were rarely present in UK policing.[3]

10.7 When Graham Power arrived in 2000, it was the established practice for major investigations to seek assistance from Devon and Cornwall Police. SOJP officers did not have the necessary skills, training or experience and the SOJP did not have a HOLMES computer, which was needed to manage a major enquiry.[4]

10.8 Many officers, in their evidence to the Inquiry, recognised that the rarity of serious crime in Jersey meant that senior officers would often not have the experience that officers of similar rank in the UK would have.

10.9 Force Legal Advisers have worked with the SOJP since the 1980s, and give advice on the preparation of cases. They also provide advice to the Honorary Police (described in more detail below). Force Legal Advisers are based in SOJP headquarters but are employed by the Law Officers' Department (LOD). During Sir Michael Birt QC's tenure as Attorney General, the law changed to enable Force Legal Advisers to appear in the Magistrate's Court even though they were not qualified Jersey lawyers or Crown Advocates.[5] Since 2007, Centeniers of the Honorary Police have not had the power to prosecute those entering not guilty pleas, and the Force Legal Advisers undertake this work.

[2] Day 121/19
[3] Day 106/98
[4] Day 106/100
[5] Day 131/12

10.10 Bridget Shaw came to Jersey from the UK in 1998, to become a Force Legal Adviser. She told the Inquiry that the Force Legal Advisers had a good working relationship with the Centeniers.

10.11 She explained that a Centenier may handle simple preliminary matters in child abuse cases (such as bail) but such cases then go on to the Royal Court and are handled by a Crown Advocate. She said that sometimes a Centenier sought to retain control of a case that the Force Legal Advisers thought should be handled by them. However, she could not recall any instance in which a Centenier had attempted to retain control of any serious case of child abuse.[6]

The Honorary Police: background

10.12 There are 12 Honorary Police Services in Jersey – one for each of the 12 Parishes. Each Police service is headed by a Connétable; below the Connétable are Centeniers, Vingteniers and Constable's Officers. The most senior Centenier in each Parish is known as the Chef de Police. Each officer is a volunteer. There are approximately 240 Honorary Police officers in Jersey.[7]

10.13 The Inquiry heard detailed evidence from Daniel Scaife, Chef de Police in St Helier, and Robert le Brocq, a former Connétable, about the structure and organisation of the Honorary Police.[8]

10.14 The SOJP may arrest a suspect but do not have the power to charge him or her with an offence. The decision whether to charge lies with the Centeniers in the Parish in which the offence was committed. If the SOJP wish an alleged offender to be charged they present a Centenier with the results of their investigation for his consideration. The Centenier may also receive written advice from the LOD or Crown Advocates. If that advice is to charge the suspect then the Centenier would do so. The SOJP do not consult a Centenier if the SOJP decide that charging would be inappropriate.[9]

[6] Day 119/10
[7] WS000657/1
[8] WS000657; Day 108/55
[9] WS0655/3; Day 114/107; WS000657/7

10.15 In deciding whether to prosecute, the Centenier follows the Code on the Decision to Prosecute. A two-stage test is applied: first, is there sufficient evidence to provide a realistic prospect of conviction? If that test is met, he considers the second stage, which is whether prosecution is in the public interest.[10]

10.16 Deputy Bob Hill made the criticism that the number of Parishes, and therefore of Centeniers, meant that there was a risk of inconsistent decision making.[11]

10.17 Robert Bonney, a retired DI who served in the SOJP from 1977 to 2005, said that the Centenier was usually willing to accept the Police recommendation to charge. If the Centenier was unwilling to charge the alleged offender then the SOJP could approach the Law Officers and request a decision from the Attorney General. Sometimes, to the frustration of the SOJP, a Centenier would refuse to charge but would take a lesser course, such as referring the alleged offender to a Parish Hall Enquiry, which was under the jurisdiction of the Honorary Police and could impose lesser sanctions than those available to a Court. Robert Bonney said that he was not aware of any Centenier deliberately shielding an individual from prosecution.[12]

The role of Centeniers in the prosecution of child abuse cases

10.18 In the early 1990s, both the SOJP and Children's Services were expressing concern about the role of Centeniers in child abuse cases. One particular Centenier was thought to be unwilling to pursue such cases. Anton Skinner, then the Children's Officer, wrote to the Bailiff in 1991, expressing concern about the lack of protection of child witnesses in the Magistrate's Court, caused in his view by the fact that Centeniers, not professional prosecutors, presented the cases.[13]

10.19 In 1993, Marnie Baudains, then Head of Children's Services, wrote a paper for the Working Party in Child Abuse Cases. She identified a number of difficulties in the prosecution of child abuse cases. She also took the view that these problems arose from the fact that a Centenier, not a lawyer, was

[10] WS000657/8; WD 008454/2
[11] Day 104/98
[12] WS000655/3
[13] WS00002/11–15; Day 126/170; WD007333

responsible for the prosecution up to and including the Magistrate's Court stage.[14] The Working Party concluded that the task should be undertaken by legally qualified prosecutors.[15]

10.20 The criticisms were well founded but changes made in recent years (including those summarised above) have addressed the failings identified. Barry Faudemer was head of the Family Protection Unit (FPT) of the SOJP as a DS from 1994 to 1996 and the DI in charge of CID with responsibility for the FPT from 1998 to 2001.[16] He said in evidence to the Inquiry that when he was a DI in the Operational Support Unit from 1996 to 1997 he encountered no particular difficulties in decision-making by Centeniers, as by that date they were assisted by lawyers when dealing with child abuse cases. He was not aware of any child protection cases being abandoned in circumstances in which the Police wanted to proceed.[17]

The division of responsibility between the States of Jersey Police and the Honorary Police

10.21 The Inquiry was shown the Jersey Child Protection Committee (JCPC) Child Protection Guidelines, drawn up by the FPT in 1998/1999. They included guidance that instructed all Honorary Officers to discuss any concerns about child abuse with their Centeniers. Furthermore, it was the responsibility of the Duty Centenier of the Parish to report all cases of suspected child abuse to the FPT.[18]

10.22 Under Chief Officer Graham Power's leadership, a memorandum of understanding was drawn up that identified which of the Police services would be responsible for different categories of crime. Serious crimes were reserved to the SOJP. Domestic abuse cases were removed from the Honorary Police as there were concerns that they were not taking such cases sufficiently

[14] WD008662/408
[15] WD008345/50
[16] WS000652/2
[17] Day 113/62
[18] WD08345/79

seriously, and were sometimes diverting cases inappropriately to Parish Hall Enquiries.[19]

10.23 DCI André Bonjour said that, in his view, the Parish Hall Enquiry system was not the right place for domestic violence issues to be addressed.[20]

10.24 DCI Alison Fossey of the SOJP said that she was aware of Parish Hall Enquiries handling child abuse cases. In her view, while it might be appropriate for some cases of very low-level neglect or assault, all other child abuse cases should go to court.

10.25 On 8 March 2006, Bridget Shaw wrote an email to DCI Alison Fossey, then a DS within the SOJP FPT, setting out her recollection that the Attorney General had issued guidance to say that cases of child neglect and cruelty should not go to a Parish Hall Enquiry. DCI Alison Fossey told us that thereafter further guidance was issued, practices changed and it was very rare for abuse cases to be sent to a Parish Hall Enquiry.[21]

Public Protection Unit: **history**

10.26 This unit was founded by the SOJP, as the Child Protection Team (CPT). In order to assist the reader to follow events involving this unit, a brief chronology, identifying the officers who gave evidence to the Inquiry and who served in, or were in charge of, the Unit, follows:

- November 1991–January 1995: DS David Morgan in charge
- 1993: Anton Cornelissen seconded for a few months
- 1993: Anton Cornelissen in Administrative Support Unit but involved with FPT work
- 1994–1996: DS Barry Faudemer in charge
- 1995: DC Emma Coxshall was seconded for two months to the FPT
- 1996: Anton Cornelissen returned in charge of the FPT
- 1997–2006: DC Emma Coxshall worked in FPT
- 1998–c.2001: DI Faudemer in charge of CID, with responsibility for FPT

[19] Day 106/107; 140
[20] Day 109/122
[21] Day 117/25; WS000687/4

- 2001–2005: DI Robert Bonney in charge of CID, with responsibility for FPT until retirement in 2005
- 2002: DC Brian Carter (joined SOJP 1998) became a member of the FPT until retirement in 2007
- January 2003–May 2007: André Bonjour was Chief Inspector for Crime Services
- August 2005–June 2006: Peter Howlett was a DS in the Unit
- December 2005: DS Alison Fossey (joined SOJP 2002 as a DC) in charge of the FPT
- January 2006–April 2008: Alison Fossey in charge, first as a DS and then a DI. (From April 2008 to October 2010, DI Alison Fossey was the Deputy SIO and then SIO of Operation Rectangle)
- June 2010–February 2013: André Bonjour returned to head Crime Services as Acting Superintendent, a post made substantive in June 2011
- June 2011 onwards: DCI Alison Fossey, DCI for Crime Operations.

10.27 The original Unit was established, as stated above, in 1989. It was dedicated to the investigation of child abuse.[22]

10.28 In the 1990s the team, then known as the FPT, focused on domestic violence and both physical and sexual offences against children. In 2007 the FPT was renamed the PPU to reflect the fact that the victims of sex offences were not exclusively children or family members.[23]

10.29 An examination of the history of the Unit assists in considering whether the SOJP now has, or from the 1990s had, the expertise necessary to investigate child abuse cases. The Inquiry did not hear sufficient evidence of policing practices and policies before the 1990s to form any concluded view about the investigation of such cases at any earlier time.

10.30 The Inquiry heard evidence from a number of former members of the Unit. David Morgan was the DS in charge of the FPU between November 1991 and January 1995. Initially the Unit only had two detectives but this was a significant commitment as the whole of CID comprised approximately 10

[22] WS000652/1; Day 113/5
[23] WD008326/103

officers. Until 2006, the Unit was headed by a DS. Thereafter the Unit was headed by its own DI with DI Alison Fossey the first to hold the post.

10.31 DS David Morgan, on taking up his post, undertook a "vulnerable victims" course at the Home Office detective training school in Kent. He subsequently attended joint training courses in Jersey with CCOs from Children's Services. This included training in interviewing child victims and in giving evidence in court.[24]

10.32 David Morgan said that the multi-disciplinary FPT worked closely with CCOs and held a meeting every Friday. They worked in accordance with the 1991 UK manual "Working Together".[25]

10.33 From 1994 to 1996, DS Barry Faudemer was head of the Unit and, from 1998 to 2001, he was the DI in charge of CID, with responsibility for the FPT.[26] He increased the team to four full-time officers. There is evidence that the Unit flourished under the leadership of Barry Faudemer, and a number of witnesses identified his commitment to the work.

10.34 Barry Faudemer told the Inquiry that he pioneered the use of covert techniques for gathering evidence in FPT cases and he also sought to raise awareness of abuse. He initiated a poster campaign in the mid-1990s and participated in media articles. His predecessor, DS David Morgan, started the work of raising the profile of this type of offending and was the driving force behind the introduction of legislation banning child pornography.[27]

Public Protection Unit: resources

10.35 Barry Faudemer believed that the FPT was given adequate resources. Four officers were "*a large chunk of CID*". He recognised that there were competing pressures for resources. He did not believe that a lack of resources had ever led to a child being put at risk or to an existing risk being prolonged.[28]

[24] WS00022/2
[25] Day 126/157
[26] WS000652/2
[27] Day 113/10; WS000652/20; Day 126/182
[28] Day 113/15

10.36 Robert Bonney was the DI of the CID and FPT from about 2001 to 2005. He was able to identify child protection issues arising from CID work and ensure that the right staff were deployed. He also believed that the FPT had sufficient resources to deal with its work.[29]

10.37 Chief Officer Graham Power acknowledged that the Unit, in the early days of his tenure, was under-resourced and not performing well. He accepted that he had failed initially to realise that there were problems. However, in 2006 he initiated a series of changes. Alison Fossey, at that time the DS at the FPT, was promoted and became the team's DI. She had specialist knowledge in the area of child protection.[30]

10.38 Graham Power told the Inquiry that DI Fossey inspected the Unit, using a Protocol from Her Majesty's Inspectorate of Constabulary, and compared the Unit's performance against expectations. The results were poor; there was no proper workload management, and no formal arrangements for sharing information with other agencies. Chief Officer Graham Power supported DI Alison Fossey in making the necessary changes.[31] Those included drafting agreements on multi-agency working, such as sharing of information with Children's Services.[32]

10.39 The arrival of Alison Fossey led to significant changes in the FPT. She updated the record-keeping system and provided a higher level of supervision. A former DC in the FPT (2002–2007), Brian Carter, said that "*things improved dramatically*" once DI Alison Fossey was in charge.[33]

10.40 In June, July and August 2006, Alison Fossey sent a series of emails to DCI André Bonjour stating that the FPT was under resourced, that it might have to decide which cases it would not investigate and that the team was "*continually firefighting*".[34]

10.41 In evidence to the Inquiry, André Bonjour accepted that the Unit did not have sufficient resources to deal with every case in which a child could be at risk.

[29] WS000655/2
[30] WS000687/1
[31] Day 106/129; WS000536/32
[32] Day 106/167
[33] WS00647/15
[34] WD008688/19; WD008688/21; WD008283/3

He said that specialist officers in one field could not be taken away from their day-to-day work to provide resources to another department. He referred to the importance to Jersey of the finance industry. He said that the States of Jersey had made funds available for the recruitment of staff to the Joint Financial Crimes Unit, following scrutiny by the International Monetary Fund.[35] The importance accorded in Jersey to the finance industry was a recurring theme in evidence before the Inquiry. It is right, though, to note that André Bonjour also emphasised, in his oral evidence, that no type of crime was prioritised over another, save that offences against people were more important than offences against property.[36] He also, in his statement, said that a States of Jersey fundamental spending review in 2002/2003 left the SOJP Crime Services Units, including the FPT, suffering from budget reduction and scarcity of resources.[37]

10.42 Alison Fossey said: *"I do feel that tougher, more informed decisions should have been taken when it came to allocating resources between the CID units and the force more generally."*[38] In her oral evidence DCI Alison Fossey was asked why she thought that in 2006 the FPT had not been given the resources needed. Her reply was:

> *"A lack of understanding of threat, harm and risk. To me child protection presents the biggest threat and risk to any Police force in the country. Jersey didn't recognise that, therefore the resources did not get prioritised to that."*[39]

10.43 The Panel accepts that the Unit was under-resourced at that time, and acknowledges that there may have been a failure on the part of more senior officers to recognise the extent of the risks involved in child protection policing. We do, though, accept the evidence of Graham Power, who said that nobody deliberately starved the FPT of funds, and that DI Alison Fossey inherited what was believed to be the correct staffing level.[40] André Bonjour told us (and pointed out to Alison Fossey in 2006) that hers was the only

[35] WS000642/7
[36] Day 109/88–90
[37] WS000642/6
[38] WS000687/6
[39] Day 117/42
[40] Day 106/165

department that was fully staffed. The email correspondence demonstrates that he was making efforts to provide additional staff.

10.44 We also have to recognise the realities faced by the SOJP. In 2006, Alison Fossey was a DS and then DI, fighting for the resources that she knew the FPT needed. More senior officers had to allocate limited resources across all Crime Services units. Those officers would have had a broader knowledge than she had of the resourcing needs of the SOJP as a whole. We accept the evidence of André Bonjour about the effect of the spending review on the SOJP.[41] John Pearson confirmed the position, telling us that, during his tenure as Head of Operations (late 2003–2007), all departments were "*crying out"* for more resources.[42]

10.45 We accept the evidence of DCI Fossey that the Unit's performance has improved very significantly since 2006. While we have no doubt that she is right to say that the Unit faces a "constant battle for resources",[43] that is an inevitable feature of any publicly funded service.

Public Protection Unit: policies and practices in recent years

10.46 DCI Fossey told us that, when she joined the FPT in December 2005, it was immediately apparent to her that the policies and practices were far behind what was considered best practice in the UK. She noted that while there were investigations, there were few prosecutions. One of her main concerns was that the FPT was leaving it to social workers to assess the situation and determine whether a criminal investigation was required. Children's Services reacted positively to her requirement for the Police to attend these early enquiries with social workers. The Emergency Response Team of Children Services knew that the Police would support them.[44]

10.47 In this section of the Report we have concentrated on SOJP policies, practices and training from 1989 onwards. We have done so because 1989 marks a significant change in child protection work within Jersey policing, with the foundation of the CPT. We have seen a number of policy documents that

[41] WS000642/6
[42] WS000685/5
[43] WS000687/67
[44] Day 117/20

have been in use during the existence of the Unit. In general terms, those policies have either been UK ones, or have mirrored those in use in the UK. DS Barry Faudemer and then DI Alison Fossey, both of whom had received training in the UK, produced their own policies for use in the Unit. Each of them headed the Unit during some of the most successful periods of its history. We address below the SOJP's practice of adopting UK training for the Unit's officers. That practice in itself would inevitably have guided the Unit's choice and application of policies. We have reached the conclusion that the policies and practices of the Unit have at all material times been adequate for the tasks that the Unit was required to undertake. We note DCI Alison Fossey's evidence that, on her arrival, policies and practices did not meet the standards of UK best practice. It seems to us, though, that the flaws may have lain predominantly in the implementation of policy, rather than in the policies themselves. She had inherited an under-resourced team which had, in its recent past, been headed by a number of sergeants, some of whom had not had an interest in this type of work; standards had slipped and morale was low. As DCI Fossey noted in her evidence to us, while she had experienced officers, they needed continuous professional development.[45]

10.48 It is clear from the evidence that the work of the FPT has progressed over the years. DS David Morgan's and DS Barry Faudemer's contributions helped to raise the profile of child abuse in the early 1990s and encourage reporting. Barry Faudemer pioneered techniques and updated policing practices. However, Graham Power acknowledged that, by 2006, the Unit was under-resourced. Thereafter, the appointment of Alison Fossey as the first DI to head the Unit clearly had a positive impact.

10.49 We accept the evidence of DCI Alison Fossey that the FPT (now known as the PPU) has improved dramatically as of today. The Unit has kept up to date with the latest training, ACPO guidance and HMIC reports. The introduction of the Multi-Agency Safeguarding Hub (MASH), which we discuss below, has led

[45] Day 117/17–18, 22

to improvements in information sharing. Policies and procedures are regularly reviewed and multi-agency working is more successful.[46]

Public Protection Unit: training

10.50 The practice of sending officers to the UK for training assisted in bringing FPT officers up to speed with current practice in the UK, such as interviewing of child witnesses through the "Achieving Best Evidence" (ABE) course.

10.51 The foundation Child Abuse Multi-Agency Training (CAMAT) that Barry Faudemer underwent in 1994/95 in Devon was significant for the FPT. He told the Inquiry that the course was attended by teachers, social workers and health visitors; of the 30 participants he was one of two Police officers. He told the Inquiry that this was the first occasion on which a SOJP officer had participated in joint training in the UK, (although DS David Morgan also said that he had attended multi-agency training in Jersey, as above). During one of the exercises, he was appalled to realise that professionals working with children were very reluctant to report abuse until a late stage. He surmised that the same would be true in Jersey and raised the issue with Marnie Baudains on his return. He then secured similar training for all new officers of the FPT and encouraged Children's Services officers to attend.

> *"Following my attendance at the CAMAT course I found that levels of awareness started to rise and there was a realisation that historic abuse cases were very important and that as a Police force we needed to marshall the evidence and grasp opportunities to put the pieces of the jigsaw together …"*[47]

10.52 Brian Carter was a member of the FPT from 2002 to 2007 and then a civilian investigator on Operation Rectangle. By the time he gave evidence to the Inquiry he was a civilian child protection case conference liaison officer. This was a role created in 2012 and entailed his attendance (in place of a Police officer) at child protection case conferences.

[46] WS000687/65
[47] WS000652/6

10.53 Brian Carter said that while there was initially no training he subsequently went on child protection courses and the ABE course that addressed techniques to be used for interviewing children.[48]

10.54 Anton Cornelissen said that, by 2006, there was "*a whole host*" of policies relating to child protection work, and that it was up to officers to make themselves familiar with those policies. The team was very well run and officers were encouraged to ask more senior officers for advice.[49]

10.55 Brian Carter said that the present situation was much better than it had been when he was working in the Unit:

> *"There is a greater package of care available with the multi-agency approach … States of Jersey Police are better equipped/trained to deal with safeguarding matters."*[50]

10.56 We accept that current levels of training within the SOJP are sufficient to enable the Unit's officers to discharge their duties properly.

The relationship between the States of Jersey Police and other agencies

10.57 Barry Faudemer said that, in the early 1980s, the level of interaction between SOJP and Children's Services was "*probably fairly limited*". It was only when the CPT was set up in 1989 that they began to work together more effectively.[51]

10.58 Barry Faudemer said that he had a very good working relationship with Marnie Baudains, head of the CPT within Social Services. Both were passionate about child protection and if either had a criticism of the other's service they could discuss the problem constructively. Barry Faudemer thought that their co-operation enabled issues to be addressed quickly and improved the outcome of investigations. During his tenure, referrals to the FPT from Children's Services increased.[52] There were weekly meetings and these were the principal means of sharing information. [53]

[48] Day 103/7
[49] Day 102/103
[50] WS00300647/3
[51] WS000652/7
[52] Day 113/39, 42
[53] Day 113/45

10.59 DCI Alison Fossey said that information sharing with other agencies, particularly the HSS, and Education Departments is crucial. We agree. She said that, in 2006, obtaining health information was particularly difficult but that this issue had been addressed with the establishment of the MASH.[54] There were also difficulties during her tenure, she said, in obtaining information out of hours from Children's Services. The Police had no out of hours' access to the At Risk Register; in an emergency they had to contact the duty CCO by telephoning the hospital switchboard. The duty officer would return the call but was often reluctant to come out at night. The duty officer had no access at home to Children's Services records and so he or she would be of limited help in any event. These difficulties were addressed and the At Risk Register made available to the Police control room.[55] However, DCI Alison Fossey said the communication between the Police and Children's Services out-of-hours team continues to be a matter of concern. The situation had improved but formal guidelines should be in place.

10.60 We accept that the introduction of the MASH has improved information sharing. We endorse DCI Alison Fossey's view that formal guidance would improve out-of-hours communication between the Police and Children's Services.

10.61 Alison Fossey became the SOJP's representative on the JCPC in 2006:

> *"The people involved were very committed but all had day jobs and were in many ways trying to do JCPC work from the side of the desk … there was very little political leadership or interest in children's issues … Unlike the UK Local Safeguarding Boards (as they are now known) pursuant to the Children's Act 2004, the JCPC was a non-statutory body. Roles, function and accountability of the JCPC and its partner agencies were not defined and this diminished its effectiveness."*[56]

10.62 In her oral evidence she added:

> *"It (the JCPC) just didn't ever appear to be high on the States' agenda … In the UK there was a very strong move towards Every Child Matters … and in Jersey it just didn't seem to particularly feature on the political agenda."* [57]

[54] Day 11 7/71
[55] Day 11 7/72
[56] WS00687/21
[57] Day 18/2

The relationship between the States of Jersey Police and politicians

10.63 John Pearson, formerly head of CID, told the Inquiry that there were occasional meetings between the SOJP and States members. The Chief Officer had a monthly briefing meeting with the Minister for Home Affairs. If any particular issue might have an impact on the community or funding implications then appropriate politicians would be briefed and invited to speak.

10.64 He said that Senator Wendy Kinnard, the Minister for Home Affairs, was *"interested in what we were doing, but did not interfere operationally with the States of Jersey Police. All operational decisions remained within the States of Jersey Police as Mr Power was very clear that operational matters were no concerns of politicians"*.[58] He added:

> *"That said there were attempts by others outside of the States of Jersey Police to involve themselves in the work that we did which I would say, did border on interference at times. The political atmosphere in Jersey was completely different to anything else that I have ever experienced. Politicians in Jersey appeared to think they can influence Police operational matters … although, as far as I was aware, they did not succeed in doing so."*[59]

10.65 Lenny Harper gave the following evidence:

> *"it was never a situation that I faced before … I never had any problems in Strathclyde even with extreme left-wing politicians, because they never attempted to interfere in areas of day-to-day policing … In Jersey it was totally different. They were trying to run what we were doing on a daily basis."*[60]

SOJP knowledge of and response to allegations of abuse of children in care

10.66 Although our Terms of Reference cover a substantial time period, in practice we have had to concentrate on events from the late 1980s onwards. A convenient and practical starting point is 1989, the year in which the CPT was established. The Inquiry has been able to take evidence from officers and former officers, each of whom worked in that team for a number of years, and who gained a real insight into child protection work. Because of the extent of their work in this field, and the fact that their experiences are relatively recent,

[58] Day 117/67
[59] WS000685/15
[60] Day 121/20

these witnesses have been able to provide extensive evidence of the Police response to allegations of abuse over the last quarter of a century.

10.67 Barry Faudemer told the Inquiry that he believed that attitudes have changed over time. In the 1980s the attitude to children in care was that these were problem children who needed discipline. As awareness grew through the 1990s of the damage that abuse could do the Police came to realise that these children were often very damaged individuals. He said that attitudes started to change before he took over as the DS of the FPT in 1994. Officers realised that, while some children at Les Chênes were very challenging, their home lives could explain their behaviour. The Police were alerted to the possibility of abuse both at home and in children's homes. Disclosure by children of abuse within both environments became "*quite commonplace*".[61] From some of the evidence we received, we are not sure that these attitudes had permeated throughout the FPT, at least by the late 1990s and early 2000s.

10.68 On 2 July 2003, Brian Carter drafted a report concerning allegations of abuse of three Les Chênes residents by members of staff. One boy, WN630, alleged that a staff member, WN654, had sought to restrain him by grabbing him by the testicles.[62] At page 11 of that report, Brian Carter noted:

> *"It would be fair to say that teenagers today are far more aware of their rights however that is not to say they know their responsibilities, this in turn is making the management of these children in care far more difficult today."*

10.69 He explained in oral evidence that he thought that children were prepared to push the boundaries, without accepting the consequences of their actions. When asked what those consequences might include, he said that he thought the use of reasonable force was *"quite acceptable"* on the part of a staff member who suspected that he might be injured by a resident.[63] He said that there was a risk of residents making malicious complaints:

> *"It is fair to say that probably when you have got a group of young boys together who have been violent and committing crimes, they are more*

[61] Day 113/37
[62] WD005740
[63] Day 103/24–25

> *difficult to control because they work as a team, they feed off each other …"*[64]

but denied that he assumed that complaints were malicious. He said that *"you are very independent when you go to these cases".*[65]

10.70 We address the investigation into the allegations of assault in more detail below. For present purposes, it is enough to record our view that, as late as 2003, at least one FPT officer was sceptical about the truthfulness of complaints by children in care. Having said that, we should note that:

- Brian Carter was an officer with a genuine wish to investigate allegations of abuse. He was one of the officers who pressed for the allegations of past abuse at Haut de la Garenne (HDLG) (discussed below) to be investigated;
- a much more senior officer, Robert Bonney, recorded at the time his disagreement with the ultimate decision not to prosecute the alleged assailant of WN630; and
- we accept Brian Carter's view that, despite his instinctive scepticism, he would approach Police enquiries with an open mind.

10.71 Peter Hewlett joined the SOJP as a young officer in 1985, and came into contact with former residents of HDLG who were living in a halfway house and had drug or alcohol problems. Some hinted that sexual abuse by male staff had taken place but their claims were not specific and were dismissed by the Police.[66]

10.72 DC Emma Coxshall (FPT, 1997–2006) said that she was not aware of any attempt to cover up or avoid investigating child abuse. She had had no suspicion during her time on the FPT that there was any form of sexual abuse in children's homes in Jersey.[67]

10.73 A number of cases of alleged abuse were reported to the SOJP in the years leading up to 2006 (the year in which the wheels were set in motion for the commencement of Operation Rectangle). The response to those allegations,

[64] Day 103/32–33
[65] Day 103/34/7–8
[66] Day 104/103
[67] WS000639/19, paragraph 83; Day 103/166–7

and to two which were considered as part of Operation Rectangle, is summarised below.

Case of WN766

10.74 WN766 was a CCO. In April 1998 (before the creation of the CPT), the SOJP received a complaint that he had sexually assaulted a six-year-old girl while visiting the girl's mother at home. DC Laisney, who went on to be a founder member of the CPT, accompanied DS Ellis to interview the mother and child. The child maintained that WN766 had put his hand up her skirt and touched her over her pants. WN766 denied that any assault had taken place. Over the course of a number of interviews, the child's account changed. She alleged that her brother had witnessed the assault; he, when interviewed, initially claimed that he had but then said that he had not. Eventually, the girl said that her report of assault was untrue. In a careful report, DS Ellis stated that he could not rely on the child's latest account as being true. He set out in detail the factors making an assault likely and unlikely, and concluded that no assault had taken place. There was no prosecution and, as far as we can tell from the limited papers, no legal advice was sought.[68]

10.75 We have insufficient evidence to determine whether the SOJP investigation was adequate. The picture changed when the complainant, after maintaining her account throughout three Police interviews, to her mother, teacher and headmaster, suddenly changed it. This is a not uncommon feature of investigative child protection work with young children. We note the obvious fairness and thoroughness of DS Ellis in his consideration of the competing elements in the case.

Case of Les Hughes

10.76 Les Hughes was a Housefather at the FGH Clos des Sables. DI Robert Bonney told us that, in 1989, during a Police investigation into allegations of abuse on the part of Les Hughes at the Home, agreement was reached with Children's Services that a representative of Children's Service, Brenda Chappell, would attend the Home shortly before the Police arrived to arrest

[68] WD006827/68–71

him. The intention was that she would arrive a few minutes before the Police. In the event she went to see him hours before the arrest (or even the previous day).

10.77 DI Robert Bonney said that he was irritated that Les Hughes had been "*tipped off*" in this way and given the chance to conceal evidence. In addition, he was "*apoplectic*" to discover that a CCO with Children's Services (known to the Inquiry as WN283) had known for some years of allegations made of abuse by Les Hughes and had not passed them on to the Police.[69] In fact, WN283 had not reported the allegations to Children's Services managers.[70]

10.78 Children's Services were, said Robert Bonney, generally supportive of Police investigations. However, this was an example of a case where there was a failure to report promptly to the SOJP. We find that the response of the SOJP, when the abuse was reported to them, was appropriate. The Police pursued a prosecution which led to Les Hughes pleading guilty to three sexual offences against children. We address this prosecution further in Chapter 11.

Case of WN335

10.79 WN16 was a resident at Heathfield from 1986 or 1987 to 1989. He alleged that a member of staff, WN335, had committed repeated and serious sexual assaults on him over a period of two years at Heathfield and, after WN216 had left Heathfield in January 1989, at WN216's own flat. WN216 alleged that the assaults had continued for a further two years. He eventually reported them in early 1991.

10.80 We have seen two reports by DS Adamson in this case. The first report indicates that he interviewed WN335, who denied the allegations and put forward a number of reasons for which WN216 might be making malicious claims against him. The Police also interviewed other members of staff at Heathfield, who provided no corroborative evidence to support a prosecution.

[69] Day 114/152; WS000655/7; WD008662/2
[70] WD008662/2

The Police attempted to obtain DNA samples from bed linen, but no matches could be obtained.[71]

10.81 In a subsequent report, made in August 1991, DS Adamson wrote that he thought that WN216 would be a reluctant witness. We do not know why he came to that view, particularly since WN216 had provided a second witness statement just three days earlier.[72]

10.82 When considering the decision not to prosecute in this case, Nicholas Griffin QC asked why the Police had not sought to interview other residents at Heathfield. He reached no conclusion, considering the issue to be outside his remit. The Inquiry has seen no evidence which would enable us to answer that question. It is possible that Police were sceptical about the prospect of relying on child witnesses whose troubled pasts could make them seem, in the eyes of a court, unreliable witnesses. We have certainly received evidence of attitudes of this sort that persisted in the Police for a decade or more after this time. However, we did not hear from DS Adamson and it would be wrong for us to speculate, either on this issue or on the question of WN216's putative unwillingness to give evidence. We do note that DS Adamson does seem to have made significant efforts to obtain corroboration; he also referred the file to the Force Legal Adviser, who endorsed DS Adamson's view that the case should not proceed. We do not criticise the Police approach to this investigation.

10.83 The case was investigated again in 2008, as part of Operation Rectangle. This time, officers did speak to former residents of Heathfield and obtained, both from former residents and from staff, evidence that potentially corroborated WN216's accounts. However, by this time, WN216 no longer wished to pursue a complaint. He felt that he had not been believed in the past and there was no reason for him to think that he would be believed now. In a report made in June 2009, DS Smith concluded that WN216 did not wish

[71] WD004681/183
[72] WD004573

to give evidence, noted that there was no forensic evidence and advised that the Police should take no further action. DI Fossey concurred with that view.[73]

10.84 As Nick Griffin noted, DS Smith's analysis took no account of the corroborative evidence obtained by the Operation Rectangle team. However, the reality was that, with WN216 unwilling to co-operate, and the corroborative material being insufficient to substantiate a case without him, there was little that the Police could do. We believe that the Operation Rectangle investigation was a thorough one, and we do not believe that the error in DS Smith's report altered the conclusion that the Police were bound to reach.

Case of WN857

10.85 In July 1991, a 13-year-old girl in foster care alleged that she had been indecently assaulted by her foster father WN857. She had been in the care of WN857 and his wife for three months. She was removed and placed at La Preference at the request of the foster mother. An undated record notes that the foster parents threatened to send her back to her real father if the Children's Office did not remove her and "*needless to say these foster parents have been wiped off the slate*".[74]

10.86 The child eventually disclosed the allegations of indecent assault to Marnie Baudains. This led to a Police investigation and disclosure of digital penetration on five occasions during her three months in foster care.[75] An examination conducted by a Police surgeon confirmed injuries consistent with her allegations.[76] The child said that she did not say anything because she was scared and "*did not know how to tell anyone as she did not think they would believe her".*

10.87 The foster father WN857 was interviewed by the SOJP on the same day. He denied the allegations and said that it was an emergency placement with them, the child having been beaten by her father.[77] His wife was also interviewed and said that she had never seen any acts of indecency. There

[73] WD008989/184, WD004572
[74] WD008598
[75] WD006607
[76] WD006608
[77] WD006609

were limited occasions on which her husband was left alone with the child. She also identified another possible perpetrator.

10.88 DS Adamson advised that while there was medical evidence to substantiate the allegations it was not conclusive of the guilt of WN857. She noted that unless there were further corroborative evidence it would be unsafe to proceed with the prosecution. She requested that a copy of the report be forwarded to the Police Legal Adviser, Ian Christmas, for his consideration.[78]

10.89 We find that the response of the SOJP to the disclosure of alleged abuse was appropriate. The child complainant was interviewed by the Police in the presence of Marnie Baudains, and the interview was recorded on video. The Police obtained a medical opinion from a child abuse expert and senior Police surgeon from Thames Valley Police. Her conclusion was that the child had suffered injuries as a result of penetrating trauma. However, proof of the identity of the perpetrator, when there were two candidates, was clearly going to be difficult to establish. We believe that the investigating officer took the right course in identifying his doubts but nevertheless seeking a legal opinion from Ian Christmas.

Case of WN858 and WN859

10.90 In June 1994, the mother of a two-year-old child in foster care alleged that the child had suffered physical abuse at the hands of the foster parents, WN858 and WN859. The allegations were reported to the SOJP on 12 June 1994. The duty CCO, David Dallain, visited the Home and had concerns about the origin of the bruises, but advised that the child be returned to the foster parents. No update was provided to the Police at that stage.

10.91 The allegations were initially investigated solely by Children's Services. After Mr Dallain's visit on 13 June 1994, arrangements were made for a medical examination of the two-year-old. The Police, at this stage, were informed that Children's Services were conducting an "in-house" investigation in what was probably a malicious complaint. The SOJP asked to be informed if there were any concerns about non-accidental injuries.

[78] WD006607/4

10.92 Dr Clifford Spratt examined the child in the presence of one of the alleged perpetrators, WN859. He concluded that the bruising indicated "*fairly heavy beatings*". WN859 requested a second opinion, and this was arranged by Children's Services. The Police were then notified on 14 June 1994 and DC Shearer attended the second medical examination. Dr Holmes's opinion was that there was insufficient evidence to justify the conclusion that the bruising was non-accidental. On 16 June 1994, a Police investigation commenced at the request of Children's Services.[79]

10.93 In her first interview with the SOJP, WN859 said that she did not know how the injuries were caused but gave possible explanations, including the child's disability and propensity to injure himself. She admitted occasionally smacking him for misbehaviour but stressed it was never hard enough to cause injury.[80] WN858 provided similar explanations when interviewed.

10.94 The child's mother told the Police that she had suspicions over some months about a series of injuries, some of which were reported to Children's Services.[81] Her concerns are recorded by Children's Services in February 1994 and in April 1994, leading to a visit by the CCO. In May 1994 it is noted that concerns were dispelled because the bond between WN859 and the child was *"excellent."*[82]

10.95 Photographs taken by the child's family were provided to both doctors. They concluded that injuries to the buttocks were the result of "*a heavy blow from open adult hand*". WN858 and WN859 were interviewed again on 12 July 1994 and maintained their denials.

10.96 On 18 July 1994, one month after the allegations were first made, a Child Protection Case Conference was held. Anton Skinner, Children's Officer, chaired the conference which was attended by two SCCOs, three CCOs and two Police officers.[83] The following information was recorded:

[79] WD005965
[80] WD006622
[81] WD005965
[82] WD009399/418
[83] WD008983

i. Two CCOs visited the foster home to investigate the bruising. The child was not stripped during their visits. Sue Richardson (CCO) noted that the child had developed well and although she was concerned about bruising she felt that this was due to him falling a lot and *"rough play with the other children"*. Sarah Brace (CCO) spoke to WN858 and WN859 about physical punishment not being an appropriate form of discipline. She felt that the foster parents provided "excellent care throughout his stay with them."

ii. The Health Visitor said that the foster parents believed in old methods of discipline and WN859 *"must have been under considerable strain"* caring for all of the children.

iii. Anton Skinner said:

a. The foster parents had in general *"provided excellent care".*

b. Corporal punishment of a foster child is not acceptable and this should be made clear.

c. The injuries reflected a loss of temper or control rather than physical chastisement – this was a *"fairly sustained attack"*.

iv. Medical evidence established that the injury happened while the child was in the care of the foster parents. It was reasonable to conclude that the child's "*fairly sustained non-accidental injuries are likely to have been sustained as a result of a loss of temper"* by WN859.

v. The child and another foster child were removed from the Foster parents early in the investigation. The child's name was not placed on the Child Protection Register as he was no longer considered to be at risk of abuse. The foster parents' own children were not placed on the register in the absence of any evidence to suggest they had been subject to abuse.

10.97 The following recommendations were made:

- No prosecution – WN858 and WN859 provided the child with "*excellent care*" and their choice of punishment was "*unwise, rather than cruel or aimed at deliberately inflicting injury".*

- Anton Skinner to inform the foster parents that their registration would be withdrawn. Further discussion to take place about appropriate forms of discipline and support to be provided by the Child and Family Unit.

10.98 Anton Skinner was asked to provide a supplementary statement to the Inquiry about this investigation. He said that he had no recollection of the case but gave an account based upon the documentation provided and his general experience.[84] He made the following points:

- The purpose of a Child Protection Conference was to ensure measures were in place to protect the child and assist the child and family as appropriate. He agreed with the measures set out in the 1991 Child Protection Guidelines.[85]
- It was not a standard function of a Child Protection Conference to make a recommendation relating to prosecution. In this case he did not think the recommendation would have influenced the Police Legal Adviser's decision about whether to prosecute.[86]
- They had no specific guidance about factors to take into account when making a recommendation as to prosecution. The Department's reputation was not a consideration. There was no political or other pressure from anyone else. WN858 and WN859 were foster parents but were not employed by the Children's Service.
- Sue Richardson made a reasonable assessment of the cause of the child's bruising, taking into account his propensity to fall over. Sarah Brace's conclusion that "*despite this incident*" the child had been provided with "*excellent care*" should have been phrased "*with the exception of this incident"* as whatever led to the loss of control it could not equate to "*excellent care*".
- Anton Skinner's recorded use of the phrase "*fairly sustained attack*" was *"an imprecise use of wording on my behalf and does not accurately represent the evidence".*

[84] WS000734/38
[85] WD009137/11
[86] WD005965/8

- The key difference, compared with the approach taken to the allegations about the Maguires in 1990, was that the wellbeing and safeguarding of the children remained the priority.
- From Anton Skinner's reading of the Case Conference minutes, it was "*clearly the view*" that WN858 and WN859's children were not at risk, particularly once the strain of caring for the foster children had been removed.
- The interests of WN858 and WN859, the alleged perpetrators, were factored into the recommendation regarding prosecution. Whatever their shortcomings, they had sought to provide a caring environment for the foster children. Prosecution would have impacted on their ability to care for their own children.
- The interests of the mother of the two-year-old child were not taken into consideration.

10.99 In the light of the Case Conference recommendations, the SOJP report concluded:[87]

- On occasions, WN859 found it difficult to cope: it is *"probable that she may have been responsible for other injuries however this cannot be substantiated".*
- The investigating officer concurs with the recommendation of the Case Conference "and is of the opinion that there is insufficient evidence to prefer charges against either [WN858 or WN859]."
- The mother of the child said she would consider civil proceedings and due to the sensitivity of the case it was forwarded to the legal adviser for consideration.
- The investigation highlighted the importance of *"immediate and full liaison between the Children's Service and the Police"*, which, it is said, *"would have made the Inquiry considerably shorter, easier and perhaps even resulted in a more positive outcome"*.
- Anton Skinner expressed his intention to conduct an internal review.

[87] WD005965/8

10.100 In his supplemental statement, Anton Skinner said that he did not know whether civil proceedings were instigated. He did not understand Police concerns about delays in liaison and thought that there were delays in the Police investigation. He had no recollection of carrying out an "internal review" but exhibited a "debriefing session" agenda that included lessons to be learned for the future.[88]

10.101 Our interest in this case is the extent to which the child protection guidelines and best practice in child protection work were followed. We recognise the SOJP were initially constrained by the limited information provided by Children's Services. The emphasis on the possibility of a malicious allegation by Children's Services was unhelpful and poor social work practice. The possibility of unfounded or malicious allegations should always be a consideration but should not prevent thorough investigation and review of the evidence. Once the SOJP investigation commenced, the weight of medical evidence should have been a primary consideration in determining whether to prefer charges. We might query the correctness of the view that there was insufficient evidence to prefer charges, but recognise that it is an issue on which different opinions could reasonably be held.

Case of WN860 and WN861

10.102 On 23 September 1994, a 19-month-old girl in foster care was taken to hospital by her foster mother WN861. She had injuries to the left side of her face. Dr Clifford Spratt found two large bruises which he deemed to be non-accidental and the SOJP and Children's Services were notified. A photograph was taken of the injuries.

10.103 WN860 and WN861 were interviewed by the SOJP on 24 September 1994. The foster father WN860 said he returned home from a run and found the child crying in her cot; later that evening he noticed a red mark around her eye. He had no idea how the bruising was caused. WN861 provided similar evidence to her husband and added that the foster child climbed onto a rocking horse and her own child helped her down by pulling her leg. She also said that the child bruised easily. They had had the foster child for about

[88] WD009399/424, 426

six months and "*She's done nothing to get a smack or a telling off, no nothing*".

10.104 A member of the CPT allocated the case to Jean Andrews, who produced a report on or about 29 September. WN861 told her that when she heard the foster child crying, she went into the room and her own son was in the room with the foster child. Jean Andrews reported that the photograph of the injury was shown to Dr Holmes, a Police surgeon. He concluded non-accidental injury and considered it unlikely that an adult inflicted the injury. He thought it possible that a flexible object was the cause and agreed with Jean Andrews when she suggested that the likeliest explanation was a soft flexible toy with some hard parts. Later in the day, Jean Andrews showed him a doll and he confirmed it was the most likely object to have caused the injury.[89] Dr Clifford Spratt agreed that the injuries could have been caused by the foster parents' son.[90] Jean Andrews concluded that the injury appeared consistent with several blows from the doll.

10.105 DS David Morgan's report, dated 20 October 1994,[91] also concluded that the injury was probably caused by the foster parents' son and that therefore there was no evidence to show a crime had been committed.

10.106 The approach of Children's Services and the SOJP in this case of non-accidental injury is different from that taken with WN859 and WN858. There was in this case no detailed investigation and no Child Protection Conference to ensure that measures were in place to protect the child. However, given the advice that the injuries were likely to have been caused accidentally by the foster parents' son, we conclude that the response of the Police was reasonable.

Case of WN862

10.107 Numerous allegations were made from at least 1995 onwards that WN862, a registered foster parent, had sexually abused WN974, his foster daughter. WN974 and her siblings were fostered by WN862 and his wife. It was also

[89] WD006403
[90] WD006615
[91] WD006614

alleged that WN862 continued to have a sexual relationship with WN974 as an adult and that he had access to her children.

10.108 In due course WN974's children sued the Minister for HSS for negligence, alleging that the Department failed to remove the children from a situation in which they were exposed to harm that would have been avoided had they been taken into care. Expert reports were prepared on each side.[92] The reports were disclosed to the Inquiry on application by the Inquiry to Commissioner Scriven who heard the case.

10.109 The litigation covered the period 1991–2000. Maria Ruegger was the expert instructed on behalf of the Plaintiffs and Stephen Pizzey the expert instructed on behalf of the defendant department.

10.110 Both experts agreed that the HSSD had failed properly to assess whether WN862 posed a risk to WN974's children. We concur with this view.

10.111 A summary of the chronology of disclosure begins in 1995. In October 1995, the maternal grandfather repeated an earlier allegation the WN974 had disclosed to him that her foster father WN862 had sexually abused her.

10.112 The CCO reporting on this allegation noted that the matter had been investigated previously and that WN974 had denied that WN862 had sexually abused her. The CCO noted that there were positive reports about WN862 and his wife during their 20 years as foster parents. She concluded that there were no grounds for Children's Services to investigate further.[93]

10.113 In late 1997 or early 1998, WN974 told her Family Support Worker that she had been sexually abused 10 years earlier. She did not identify the perpetrator and said that although she and her children continued to see him she had no concerns for her children.[94]

10.114 In May 1998, a Case Conference was held.[95] The notes recorded that allegations had been raised in a March 1998 memo that WN862 continued to have sexual relations with an individual who had been his foster child. The

[92] WD008973 to WD008982
[93] WD008979/31
[94] WD008979/32
[95] WD006606

individual concerned lived in a facility managed by the States of Jersey. The Manager of the facility said that, since the concern had come to his attention, staff had recorded daily visits to WN974 by WN862.

10.115 The Case Conference made the following recommendations:

- The SOJP obtain further information by following WN862 when he visited WN974. Also WN974 to be spoken to again by the Police.
- WN862 to be invited to the Children's Office to discuss the concerns with a senior member of the Service.
- WN862's movements at the facility to be monitored and a PNC check in England to be undertaken.

10.116 In a SOJP report summary completed by DC Emma Coxshall[96] she noted that Police observations had not identified any inappropriate behaviour during WN862's visits. WN974's sister had provided a witness statement the previous year. This stated that WN974 had disclosed to her that WN862 had abused her from the age of 12. The Police finally spoke to WN974 who was concerned that if she confirmed her sister's account that would mean that those of her siblings still in the care of WN862 would be removed. She said that she wanted to put her past behind her and not talk about it. DC Emma Coxshall stated that there would be no further Police investigation, given her wish not to make a complaint. The file was to be forwarded to Children's Services as WN862 was still a foster parent.

10.117 Children's Services' reports from 1999 included WN974's allegations against WN862 and noted that she continued to leave her children in his care on the basis of her belief that they were too young to be at risk. A subsequent version of the report was filed with the court with the reference to WN862 removed. Maria Ruegger (the Plaintiff's expert) considered the removal of this reference to WN862 "*to be indicative of an active intention to withhold from the court relevant information pertaining to the safety of WN974's children".* Furthermore, she said that no proper assessment of WN862 had

[96] WD006604

taken place and he was having unsupervised contact with one of the children of WN974.

10.118 In February 2000, WN974 repeated her allegations and, in October 2000, reported that WN862 still asked her for sex.[97]

10.119 In 2001, Tony Le Sueur of Children's Services expressed criticism of previous investigations. He recorded his decision not to place any other children with WN862 and his wife and stated that, once the children in their care came of age in January 2003, they would be deregistered as foster parents.[98]

10.120 In November 2005, a strategy meeting was held, apparently after a further disclosure from WN974. It was claimed during the meeting that, despite concern raised in 2000 about WN862, the matter had never been investigated by Children's Services. It was agreed therefore that there should be an investigation by the SOJP's FPT.

10.121 At a Case Conference on 27 February 2006 in respect of her children, WN974 again repeated the allegation against WN862 but refused to cooperate with the SOJP.[99]

10.122 On 8 March 2006, the Police Legal Adviser, Bridget Shaw, sent a memo to the Solicitor General. She raised the question as to whether the SOJP could begin an investigation without a formal complaint in view of the way the recent disclosures had been made. She also queried whether an enquiry should be commenced into the children fostered in the past by WN862 and his wife. It was noted that the SOJP recognised an urgent child protection issue regarding WN974's children and those in WN862's care. The memo noted: *"Children's Services have no plans to take care proceedings in respect of* [WN974]'s *children."*[100]

[97] WD008979/32
[98] WD008979/31
[99] WD008647
[100] WD008646

10.123 On 27 April 2006, the Solicitor General advised[101] that without a complaint from WN974 there was virtually nothing against WN862 that could form the basis of any court proceedings, whether criminal or protective under the *Children (Jersey) Law 2002*. The situation could be reviewed if there were further developments.

10.124 This advice was confirmed by Bridget Shaw in an email to DS Alison Fossey on 2 May 2006.[102] It was suggested that further approaches be made to WN974. Bridget Shaw also advised that an investigation be commenced to determine whether any former foster child had a complaint to make against WN862. She stated that this would not be an enquiry into the past workings of the Children's Service "*at this stage".*

10.125 WN974 again refused to co-operate. After a trawl of Social Services records, seven children fostered on a long-term basis by WN862 and his wife were identified. Five were contacted and none disclosed any abuse. DS Fossey noted that there would be no further Police involvement but that Children's Services would continue to work with WN862 and WN974's family.[103]

10.126 Officers made reasonable efforts to obtain the co-operation of WN974 and to identify other potential witnesses among former foster children. In the absence of any admissible evidence, there was little more that the Police could do by way of investigation or steps to prosecute. Given that SOJP recognised the present risk to WN974's children and to any other foster children in the care of WN862 and were aware that Children's Services planned to take no action, representations of SOJP's concerns could and should have been made at senior management level between the two agencies.

10.127 We address the response of Children's Services in more detail in Chapter 9. We consider the response of Children's Services to have fallen far short of acceptable professional standards of child protection practice. WN862 remained a registered foster parent and WN974's children were left in his

[101] WD008642
[102] WD008645
[103] WD008647

care. The evidence indicated that he had unsupervised access to one of these children.

Case of WN874

10.128 In 1998, WN875 alleged she had been abused in the past by her foster father WN874. WN875 and WN876 were originally placed in May 1978 with WN874 and his wife in a private arrangement. WN874 and his wife then applied to become registered foster parents and were vetted by Children's Services. The two children (then 11 and 12 years of age) were formally received into care in March 1979.[104]

10.129 Following the allegation made in 1998 there was correspondence between the SOJP Chief Officer, the Attorney General and the Home Office.[105] The following was noted:

- WN875 and WN876's father committed suicide in 1991. He left a note that alleged that WN874 had abused his daughter, WN875, before she reached the age of 14.
- Anecdotal and uncorroborated information about WN874 did not provide sufficient evidence for an investigation.
- WN874 had received offensive telephone calls from WN876 over a lengthy period of time.
- WN876 telephoned the SOJP and said that she had become pregnant by WN874 on three or four occasions and that those pregnancies were terminated.
- In September 1998, WN876 sent a letter to Senator Shenton about the allegations and the FPT was directed to make enquiries.
- In November 1998 and January 1999, statements were taken by the Police from WN875. She withdrew her complaint in March 1999.
- In February 1999, the SOJP interviewed WN874 who denied all allegations of physical and sexual abuse. The Inquiry obtained the transcripts of WN874's Police interviews. He admitted that he had a sexual relationship with WN875 and "*possibly got her pregnant*". He stated that this happened

[104] WD006811
[105] WD007420; WD007973; WD007420

when she was over 16 years of age. He also admitted paying her the sum of £38,000 over a number of years.[106]

- The SOJP's Chief Officer Le Breton concluded that the matter could not be put before a court. The historical and uncorroborated nature of the allegations and the character of the complainants made prosecution unlikely in his view.

10.130 A record of WN875's and WN876's contact with the Police up to 2003 was provided to the Inquiry. A SOJP report in November 2008 noted that despite the admissions detailed above no further action was to be taken as WN875's sister refused to deal with the Police and the complaint was subsequently withdrawn.

10.131 We recognise that, once WN875 had withdrawn her complaint, and in the absence of any corroborating evidence, a prosecution was unlikely to succeed. We do query whether further inquiries could have been made following WN874's admission that he had had a sexual relationship and possibly got her pregnant. Any information about the termination of pregnancy might have led to proof of WN875's age at the time. However, we acknowledge that even such proof would not establish that WN874 was the father. Again, we conclude that the Police response was reasonable.

Case of WN761

10.132 Barry Faudemer gave evidence about the case in 2001 of a Les Chênes resident, WN761, a young man with a history of violence who was charged with assaulting staff. WN761 alleged that he had been assaulted by staff; a member of staff admitted squeezing WN761's throat. However the Police and Ian Christmas, the Force Legal Adviser, took the view that contact occurred during an altercation when staff were trying to move WN761 to the secure area. The Police concluded that the restraint had not been conducted well by untrained staff and that there were institutional issues that needed to be resolved. There was no prosecution but the incident report prompted

[106] WD007975; WD006846

Barry Faudemer to go to the Director of Education and this led to the commissioning of the Dr Kathie Bull Report.[107]

10.133 Brian Carter recalled dealing with allegations, by residents at Les Chênes, of physical abuse by staff. He did not recall any prosecutions brought as a result of those complaints.[108]

10.134 We regard the Police response and, in particular, the action of Barry Faudemer in making a report to the Director of Education, as appropriate and conscientious. Prosecution was clearly not likely to succeed. However, further scrutiny of methods of restraint was undoubtedly needed.

Case of WN812 and WN813: family allegations

10.135 On 18 August 2002, allegations of buggery and indecent assault were made by foster children against WN884, the 18-year-old son of the foster parents WN812 and WN813. Documents produced by Children's Services provide a timeline of the action taken following the disclosure:[109]

- The disclosure was made to their mother, who notified the out-of-hours duty officer of the same. David Castledine visited the following day and, on 20 August 2002, ABE[110] interviews were conducted with the children. The children's CCOs were present during the interviews.
- On 21 August 2002, a strategy meeting was held involving senior managers from Children's Services and DS Shearer from the SOJP's FPT. Action agreed included the arrest of the suspect. The foster parents to be suspended pending the outcome of the enquiry.
- On 31 August 2002, WN884 was arrested. An investigation was initiated by Children's Services into the files of all children fostered by WN812 and WN813. Alternative placements were found for those in their care at the time.
- WN890, having been fostered by WN812 and WN813, was adopted by them in June 2002. On 16 September 2002, a CCO report recommended

[107] Day 113/71
[108] WS000647/4 and 16
[109] WD008746
[110] Achieving Best Evidence

that he remain in the family home and that he need not be placed on the Child Protection Register.

10.136 In April 2003, Tony Le Sueur recommended, subject to consideration by an independent fostering panel, that WN812 and WN813's registration should not be activated as WN884 was an unacceptable risk.

19.137 A Police report[111] recorded the following:

- The foster parents were seen as a *"tremendous asset for the Children's Service"*.
- The mother of two of the foster children claimed that she had told David Castledine, about 12 months previously, that the suspect had pulled down her daughter's pants.
- The foster parents provided information suggesting that the complainants were less than credible witnesses.
- Some witness statements that suggested that Children's Services had knowledge of specific incidents.
- David Castledine provided an assessment of the child witnesses in respect of their capability and credibility and the potential effect upon them of giving evidence. David Castledine recommended that neither of the two children for whom he was the CCO should be asked to give evidence.
- *"The Children's Service would like a definite result, i.e. proof of innocence or proof of guilty. Without this they are unlikely to be unable to allow (the foster parents) to resume fostering."*

10.138 DS Robert Bonney noted, on review of the file *"notwithstanding that a conviction may well be achievable and entirely in the public interest I have serious reservations over the wisdom of launching a prosecution".* He concluded that it would not be wise to bring charges given that conviction was not a foregone conclusion and mindful of the views of David Castledine as to the detrimental effect on the child witnesses. The file was passed to Police Legal Adviser Bridget Shaw *"in light of the size and circumstances of*

[111] WD005966

the enquiry, particularly the fostering element aligned with the Children's Service".

10.139 In March 2003, WN884 was notified that he would not be prosecuted. The LOD did not believe that a prosecution was in the children's best interests.[112] This was despite the fact that the investigating team believed the children's accounts.

10.140 David Castledine told the Inquiry that he recommended that the child witnesses not give evidence because of the potential psychological impact upon them being cross-examined by a defence lawyer. When asked upon what expertise his assessment of the children was based he stated he was aware of the serious effect of cross examination. He thought it wrong "*to put them through that".* He confirmed that he was not fully aware of the protection afforded to child witnesses as at 2003.

10.141 In 2010, WN890, the adopted son of WN812 and WN813, disclosed that he had been sexually abused since the age of 13 by WN747. WN747 had lived with the family for two years as a lodger and was the ex-boyfriend of the daughter of WN812 and WN813.

10.142 In 2011, WN747 was convicted of 12 counts of sexual offences against WN890 and others. He was sentenced to five years' imprisonment and two years consecutive for indecent image offences; a total of seven years' imprisonment.

10.143 After WN747's conviction WN812 was charged with and pleaded guilty to one count of perverting the course of justice. She "*tipped off*" WN747 about the investigation and allowed him to destroy evidence on his computer. She also pleaded guilty to perjury in respect of the false evidence she gave during the trial of WN747. In December 2012, WN812 was sentenced to a total of 15 months' imprisonment.[113]

10.144 We find that the Police response was appropriate. The allegations were investigated promptly, the Police liaised closely with Children's Services and

[112] WD008746/28
[113] WD006229/15

obtained legal advice. The decision not to prosecute was taken by the Law Officers.

10.145 We set out in Chapter 9 our view of the response of Children's Services

Allegations by WN630 and others

10.146 On 2 July 2003, Brian Carter drafted a report concerning allegations, made by residents at Les Chênes, of abuse by staff. In evidence, he said he considered that the use of reasonable force was "*quite acceptable*" on the part of a member of staff who suspected that he might be injured by a resident. He said that there was a risk of residents making malicious complaints. He denied that he assumed that any complaints made were malicious.[114] We have set out above further details of his report, and of his evidence to us about his views of Les Chênes residents.

10.147 In respect of one allegation of assault, however, Brian Carter concluded that the member of staff, WN654, had used an improper method of restraint (pulling the boy's arms backwards through his legs, so putting pressure on the boy's testicles). Children's Services were told of Police concerns regarding the lack of restraint training. Brian Carter recommended that WN654 should not be prosecuted even though the incident was witnessed by two members of staff as well as other residents. He considered that the offence had "*not been proved beyond reasonable doubt"* and stated that the residents were not ideal witnesses because of their previous convictions. He was also concerned about the fact that the staff members had not initially admitted to having seen the incident but had come forward later.

10.148 The file was sent to the LOD, who advised against prosecuting, noting *"this was a justifiable assault and that only reasonable force was used"*.[115] DI Robert Bonney disagreed: *"I do not believe that act is justified and to condone that sort of behaviour will be likely in my view to lead to a greater potential for unrest and serious violence."* WN654 was not prosecuted.

[114] Day 103/34
[115] WD008662/434

10.149 We believe that Brian Carter's response was wrong. He was, we conclude, too heavily influenced by his perceptions of the character of the residents of Les Chênes. Such influence is clearly a matter for concern. DC Brian Carter also, as Robert Bonney acknowledged in evidence to us, applied the wrong test; it was for the Police to determine whether there was a prima facie case to go to the Law Officers, not to decide whether the case had been proved beyond reasonable doubt. Despite Brian Carter's view (with which his sergeant, DS Beghin, concurred), the file was sent to the LOD. Further, when the advice was not to prosecute, DI Robert Bonney expressed his disagreement in trenchant terms. Ultimately, the decision whether to prosecute was one for the Law Officers, and the Police cannot be criticised for the actions that they took.

Case of WN195

10.150 In 2004, Brian Carter investigated the allegation of WN195 that he had been abused by WN264 while he, WN195, was a child resident at HDLG and WN264 had been a visitor to the Home. WN195 had raised the allegation of abuse in November 2003, while being interviewed under caution for an offence against WN264. However, the allegation does not appear to have been passed onto the FPT or, at least, was not investigated by the team at that stage. It was only after the allegation was made in court, months later, as part of WN195's mitigation, and WN195 was advised to make a formal complaint, that the FPT learned of the alleged abuse.[116] Brian Carter said that he believed WN195 and regarded him as a compelling witness; however, his understanding was that corroboration was required for any prosecution to be brought.[117] In seeking corroboration, Brian Carter reviewed the HDLG records of around 950 or 960 former residents. He was searching for records of visitors or of children being taken out of the Home on trips.[118] While he found evidence that WN264 had visited the Home, the dates did not entirely match those identified by WN195. No other resident made any complaint, save for one who (during the course of Operation Rectangle some time later) made an allegation of an assault of a very minor nature.

[116] Day 103/48
[117] Day 103/52
[118] WS000647/10

When the Law Officers decided not to prosecute, Brian Carter was disappointed but believed that the decision had been made in good faith.[119]

10.151 Robert Bonney, the DI responsible for the FPT at the time, gave similar evidence about the decision not to proceed. He discussed it at length with Laurence O'Donnell, the Force Legal Adviser, but understood that Laurence O'Donnell believed that the absence of corroborative evidence of anything beyond a propensity to an interest in young boys would lead the case to fail. Robert Bonney had wanted advice to be taken from a senior Crown advocate; the case was then reviewed by the Attorney General, who again concluded that the case could not be prosecuted without further corroboration. Robert Bonney's own view was that WN195 was a credible witness and that a jury should have been allowed to decide the case, with or without a corroboration warning.[120]

10.152 A contemporaneous note, dated September 2004, records that the Attorney General had decided that the case could not *"at present"* be prosecuted without further corroboration.[121] The author of the note, Laurence O'Donnell, wrote:

> *"I note that there are no other victims identified as a consequence of the Police investigation and thus, at present, the prosecution would proceed with only one victim. The practice locally is for such prosecutions not to be proceeded with and I am of the view that, should the matter be charged, the magistrate would discharge at an old-style committal."*

10.153 The note was sent to Brian Carter. He understood the reference to not prosecuting if there was only one victim to be a reference to the need for corroboration.[122]

10.154 While we have concerns that the original report made in November 2003 was not passed to the FPT, the response of that team once a complaint had been made was entirely proper. DC Brian Carter in particular made great efforts to obtain corroboration, and cannot be criticised for not having succeeded. Again, the matter was referred appropriately for legal advice,

[119] Day 103/54–55
[120] Day 114/176–184
[121] WD007441/4
[122] Day 103/57

and the ultimate decision not to prosecute was made by lawyers and not Police officers.

10.155 The case was reviewed as part of Operation Rectangle. John Edmonds, Director of the Criminal Division of the LOD, was asked to locate the advice given in 2004, In an email written on 14 July 2009 to the Attorney General, William Bailhache QC, he referred to the advice and said:

> *"I cannot help feeling that the Legal Advisers over a period of many years have effectively been applying a test of mandatory corroboration rather than properly evaluating whether an uncorroborated victim would nonetheless be regarded as a witness of truth. I fear that Ian Christmas' involvement both as Legal Adviser and Magistrate set the tone for much of this practice."*[123]

10.156 In 2010, Crown Advocate Baker nevertheless advised, on the evidence available, that there should be no prosecution.

Case of WN865

10.157 In August 2006, a 14-year-old girl alleged that she had been indecently assaulted by her foster mother's fiancé, WN865. A SOJP case summary[124] noted that the girl told the foster mother immediately. The foster mother gave a statement to the Police that WN865 had admitted touching her breasts but denied the other allegations. WN865 was convicted in April 2007 and sentenced to a community service order.[125]

10.158 In May 2007, a report was produced for the Fostering Panel about the continuing placement of the complainant with the foster mother.[126] The report provided a history of placements including concerns about some of the foster mother's relationships. It also set out the "current" situation, including the foster mother's request for her partner to stay at the Home at weekends despite a 2006 conviction for assaulting an eight-year-old child. A list of risk factors and protective factors in maintaining the placement was set out. The recommendation was that the complainant continue to live with the foster mother but for her registration to cease when the child was no longer

[123] WD009000/432
[124] WD006624
[125] WD006279/1; WD008594/11
[126] WD008594

in care. Close monitoring was to take place during the placement and restrictions were to apply regarding the involvement of the foster mother's partner.

10.159 We conclude that the Police response appears to have been prompt and led to the conviction of WN865. From the evidence available to us, the Police handling of the case appears appropriate.

10.160 We address the response of Children's Services in Chapter 9.

Case of WN743

10.161 During Operation Rectangle, an allegation was made by WN167 that while in foster care she was sexually abused by WN743, the son of the foster parents. WN743 was interviewed by the SOJP and he denied the allegations.[127]

10.162 The foster parents, WN895 and WN896, were also seen by the SOJP. WN896 said that she used to work at HDLG which is where she met WN167 and other foster children. The States had agreed that the family could foster the children. When the allegations against her son were explained, WN895 called WN167 a liar and denied that she was ever told about the abuse.

10.163 Richard Davenport, WN167's[128] CCO at the time, gave a statement to the Police. He denied that WN167 ever disclosed sexual abuse by WN743. He denied that he told her to put this "*behind her*" and that he would ensure they did not foster more children.

10.164 We deal in detail below with the cases that were investigated as part of Operation Rectangle. In essence, our conclusion is that the Rectangle cases were all appropriately managed by the SOJP.

[127] WD006592; WD006593
[128] WD006598

Case of WN569 and WN744

10.165 In about 1984, WN569, a registered foster parent with whom WN140 was placed, was convicted of inciting gross indecency against his daughters and was imprisoned.[129]

10.166 In 2008, allegations of sexual abuse were made against WN569 by WN140, a child in care who had been fostered by WN569. WN569 pleaded guilty in 2009 and was sentenced to 12 months' imprisonment.

10.167 WN140 also made allegations in 2008 that, when in the foster home, he was, on occasions, woken up at night by someone masturbating him. He shared a room with WN744, his foster brother.

10.168 In 2000, WN744 was convicted, in another country, of four indecent assaults on males under the age of 16. In 2002, while undergoing treatment, he confessed to a psychologist that he sexually abused his foster brother WN140 for about four years: he "*knew his foster brother would not say anything, as he did not want to be removed from the family and because he did not think he would be believed*".[130]

10.169 Following this disclosure, a report was passed to the Jersey Probation and After Care Service on the basis that WN744 was returning to Jersey at the end of his sentence. In a memo to the SOJP, is noted that a Risk Assessment Management System (RAMAS) meeting would be convened to assess the risk that WN744 posed to children (WD004970).

10.170 After WN140's disclosure in 2008, WN744 was interviewed and answered "no comment" to all questions. He was charged in December 2009 with three counts of indecent assault and was acquitted.

10.171 We consider that the Police response in 2008 was a proper one.

Case of Thomas Hamon

10.172 Brian Carter also investigated the case against Thomas Hamon over allegations of historic sexual abuse. The investigation lasted from 2004 to

[129] The Inquiry has not received any contemporaneous record of this conviction, but reference is made to it at WD004971/1
[130] WD004972

2006. Initially, there was only one complainant, who had had contact with Thomas Hamon through their shared involvement with St John Ambulance. Brian Carter obtained all the records of St John Ambulance members from 1965 to 1988 and then, through the use of a questionnaire which contained open questions, and did not name Thomas Hamon, was able to identify further victims.[131] Prosecution was pursued. Brian Carter told us that he received support from his sergeants and from DI Robert Bonney. There was, he said, no reluctance within the Department to investigate complaints of historic abuse at HDLG. However, when the department was busy, current work had to take priority over historical investigations.[132]

10.173 We accept that current work involving the present risk to children must often take priority over investigations into events in the more distant past. We also received evidence that the resources of the FPT were often stretched. It is clear, though, that this inquiry was pursued diligently; substantial and successful efforts were made to identify further victims, and prosecutions were pursued in respect of those victims.

Case of Jane and Alan Maguire

10.174 In 1990, two trainee care workers reported to Children's Services allegations that Jane and Alan Maguire, Houseparents of a FGH, had washed out children's mouths with soap, thrown a child across a room and hit children. No report was made to the SOJP. Robert Bonney described that failure as *"inexcusable"*.[133]

10.175 The allegations covered the period from 1980 to 1990. It was not until 1997 that Children's Services made a report to the Police. We set out in detail in Chapter 11 the history of the subsequent Police investigations and attempts to prosecute the Maguires. In 1997 the Police identified and interviewed a number of complainants and witnesses. A prosecution was commenced but was discontinued, following advice from Ian Christmas, a Force Legal Adviser, who expressed doubts about the nature and age of the witnesses and the vagueness of their evidence. His view was endorsed by Crown

[131] WS000647/13
[132] Day 103/59
[133] Day 114/165/130

Advocate Binnington, to whom the case had been passed for prosecution. Although not a reason for abandoning the prosecution, evidence was also received by prosecutors in 1998 that Alan Maguire was gravely ill.

10.176 The case was reconsidered as part of Operation Rectangle. Meanwhile, the Maguires had moved to France. The advice of the Law Officers and independent counsel was that, in the absence of compelling new evidence, the court would rule that an attempt to prosecute, having discontinued the prosecution in 1998, would be an abuse of process. At the request of Michael Gradwell, who had just arrived in Jersey to take on the role of Senior Investigating Officer (SIO) for Operation Rectangle, the Police were given more time to attempt to interview Alan Maguire; it was hoped that a confession might be regarded as sufficient new evidence. Alan Maguire refused to see the Police, and attempts to prosecute were abandoned for the second time in 2009.

10.177 The SOJP officers in 1998 and from 2008 showed dedication and tenacity in pursuing all available options. The prosecution was discontinued on each occasion by lawyers.

Difficulties in the relationship between the SOJP and Children's Services

10.178 We have considered above the Police view that the failure of Children's Services to report to the Police, in 1990, allegations of abuse by Jane and Alan Maguire was inexcusable. SOJP officers gave evidence that the Long-Term Team often opposed prosecution and opposed the removal of children from potentially abusive home environments. DCI Alison Fossey and Anton Cornelissen said that the Long-Term Team focused too much on a wish to keep a family together. Anton Cornelissen said that members of the team sometimes undermined the SOJP by telling a family that a prosecution was at the insistence of the Police and against the wishes of the Long-Term Team.[134]

[134] Day 102/107

10.179 DCI Alison Fossey said that she quickly developed a positive working relationship with the Emergency Duty Team but that *"relations with the Long-Term Team were more difficult*". She said:

> *"The Long-Term Team were very slow in reporting suspected criminal offences to the States of Jersey Police and they placed a heavy reliance on the States of Jersey Police to take action rather than taking more initiative themselves. For example, Children's Services seemed reliant on the States of Jersey Police to initiate criminal investigations rather than apply for an Emergency Protection Order or a Care Order of their own volition. We were constantly met with the response that the legal advice was that an application would not succeed."*[135]

10.180 Alison Fossey was sufficiently concerned, in April 2006, to write a memorandum to DCI Bonjour and to Bridget Shaw, the LOD lawyer working with the SOJP, about the working practices within a Children's Services and the Long-Term Team in particular. She made specific criticism of Danny Wherry who she said, as Chairman of Case Conferences, would arrive at conferences with his mind made up and announce his decision at the outset.[136] DCI Alison Fossey told the Inquiry that this was not conducive to an open discussion and joint working between the various agencies.

10.181 Bridget Shaw passed on those concerns to the Solicitor General in a report dated 23 May 2006 and raised her own concerns that Children's Services were waiting for the Police to act. She noted that Children's Services did not appear to understand that they could take civil proceedings in which the standard of proof was lower than in criminal proceedings.[137]

10.182 The issues raised were taken seriously. On 6 June 2006, the Solicitor General, Bridget Shaw, DCI André Bonjour and DS Alison Fossey met to discuss the points raised.

10.183 Bridget Shaw then met Marnie Baudains and Tony Le Sueur from Children's Services. However, the Police view was that the situation did not improve but in fact deteriorated. By November 2007, some members of the Emergency Team had left and "*delays and questionable judgement issues remain*",[138]

[135] WS000687/7/30; Day 117/43
[136] WD008688/26; Day 117/56
[137] WD008696/52
[138] WD005327/9

said Bridget Shaw in a memorandum to the Attorney General dated 15 November 2007.

10.184 On 15 November 2007, Bridget Shaw sent a lengthy report to the Attorney General, William Bailhache QC, in which she set out the concerns about Children's Services that she and the Police held.[139]

10.185 She also summarised the response of Children's Services to criticism:

> *"Overall they believed they were doing a good job but felt unable to apply for court orders or to take children into care as the standards set by the court were very high … the driving force behind these decisions seems too often to be whether Children's Services have suitable accommodation for the child rather than whether the child is at risk of harm if he or she stays in the home."*[140]

10.186 Bridget Shaw expressed her own view, which we endorse:

> *"When parents cannot or will not protect a child surely the State has a duty to act."*[141]

10.187 In his evidence to this Inquiry, Danny Wherry criticised the approach of the Police. He said that the FPT was staffed by inexperienced officers and that the Police sought to take control of the relationship with Children's Services. He said the Police would push for a child to be taken away from his or her family. DCI Alison Fossey rejected his criticisms. She said that the essential issue was that of risk to the child. In her view the Long-Term Team tended to focus too much on keeping a child with his or her family and did not consider the child's right to have a safe life.[142]

10.188 In our judgement, the Police criticisms of the Long-Term Team were well founded. The response of the Police and lawyers to the perceived problems was appropriate. Certainly from 2006, when DS Alison Fossey took command of the FPT, the team was staffed with well-trained and well-motivated officers. As we have noted above, DCI Alison Fossey told us that the officers she inherited had experience but needed continuous professional development. She put the necessary policies and training in

[139] WD005327/5
[140] WD005327/9
[141] WD005327/10
[142] Day 117/58; WS000687/10

place. Further, DCI Alison Fossey was herself a very experienced officer, having been recruited to her role precisely because of her expertise in child protection work. We therefore reject Danny Wherry's view that the officers of the FPT lacked experience. We accept that, when there were differences of view between the Police and Children's Services, a vehemently expressed Police view that action should be taken could be construed by Danny Wherry as an attempt to take control of the relationship.

The Victoria College, Paul Every and Sea Cadets investigations

10.189 The SOJP investigations into Victoria College, Paul Every and the Sea Cadets are not within the Inquiry's Terms of Reference. We considered evidence about these investigations on the basis that the conduct and attitude of Police officers and others to those investigations might be relevant to the Police response to allegations of abuse of children in care. Further, these investigations all preceded and formed part of the background to the SOJP's major investigation into historic child abuse: Operation Rectangle.

Victoria College

10.190 In 1996, the SOJP launched an investigation into the abuse of boys by Mr Jervis-Dykes, a teacher at the college.

10.191 Anton Cornelissen was seconded to the FPT to assist DS Barry Faudemer with the investigation. There was an allegation that Mr Jervis-Dykes had taken boys to the Jersey Yacht Club. Anton Cornelissen said that he was made to wait outside while DI John de la Haye went in to inspect the visitors' book. He returned, not having seized the book, saying there was nothing of interest. Anton Cornelissen, in oral evidence, agreed that DI John de la Haye could have formed the honest view that there was nothing to be gained from the visitors' book. He also accepted that there was no suggestion that any Police officer witnessed Mr Jervis-Dykes behaving inappropriately at the Club.

10.192 Videotapes were seized from Mr Jervis-Dykes. A reviewing officer missed a section of tape which showed a sexual assault. Anton Cornelissen's view was that the officer had made an honest mistake either through fast

forwarding the table or through an erroneous belief that the passage in question was commercial footage, not footage showing Mr Jervis-Dykes.[143]

10.193 DS Barry Faudemer was succeeded as the DS in charge of the FPT by DS Pryke (now deceased). Anton Cornelissen was critical of DS Pryke's lack of progress with the investigation but agreed that DS Pryke had not sought to close down the investigation, which was a recommendation he could have made.[144]

10.194 During the course of his work, a box of material relating to the investigation disappeared from Anton Cornelissen's desk. When DS Pryke left the SOJP through illness and his Police locker was cleared, some of the missing material was discovered.

10.195 DS Barry Faudemer told the Inquiry that he was aware at the time that DS Pryke had removed files. He believed that this was simply an attempt to make room for further storage in an overcrowded office and that DS Pryke did not see the value of the intelligence files and so was putting them to one side. As far as DS Barry Faudemer was aware, no files had been destroyed. He regarded DS Pryke as a very motivated officer whose performance had dipped considerably while in the FPT; with hindsight he attributed these difficulties to DS Pryke's then undiagnosed illness.[145]

10.196 In 1999, Mr Jervis-Dykes pleaded guilty to indecently assaulting a number of pupils and was sentenced to four years' imprisonment.

10.197 Barry Faudemer told the Inquiry that, on 3 November 2015, he had been given access by the SOJP to the Victoria College investigation files. They were intact and complete; they still bore the seals that he had put on them. He wished to reassure the victims who had come forward that their evidence had not been lost and was held securely.[146]

10.198 Sir Michael Birt, Attorney General at the relevant time, told the Inquiry:

[143] Day 102/45
[144] Day 102/74
[145] Day 113/93
[146] WS000678; Day 113/91

> *"At the conclusion of the investigation the States of Jersey Police reported to me that they did not feel that they had the cooperation and support of certain staff at Victoria College … I considered that the report (provided to me by the States of Jersey Police) raised matters that the Governors ought to be aware of and therefore wrote to them suggesting that they look into the matter raised. As a result they procured the preparation of the Sharp Report."*[147]

10.199 In 1999, an investigation report completed by Steven Sharp (the "Sharp Report") concluded that if the correct procedures had been followed by the school it is most likely that Mr Jervis-Dykes would have been suspended and perhaps arrested in 1992.

Paul Every

10.200 Paul Every was a senior civil servant in Jersey, identified during the course of the FBI's Operation Ore as having obtained access to websites featuring child pornography. He was also an officer in the Jersey Sea Cadets.

10.201 In his witness statement, Lenny Harper referred to long delays on the part of the LOD making charging decisions in respect of Paul Every. Lenny Harper however failed to acknowledge that owing to the partial deletion of the hard disk it was necessary to have the computer examined by a forensic engineer. During the investigation, the LOD provided advice on how best to put together the case against Paul Every.

10.202 The SOJP were not persuaded that Paul Every could be charged and in June 2005 concluded:

> *" … because there are no images retained on the seized computer and there is no evidence of such images having been viewed there is insufficient evidence to found a prosecution".* [148]

10.203 When the Attorney General reviewed the case he identified offences not previously considered. Paul Every was prosecuted and convicted.[149]

[147] WS000608/15
[148] WD009017/57
[149] Day 121/63–67

10.204 There was a suspicion that someone within the SOJP "tipped off" Paul Every as his computer had been wiped clean shortly before Police searched his home. However the Inquiry heard that Paul Every had software on his computer designed to wipe its contents on a regular basis. We heard no evidence that he was "tipped off" about the search.

The Sea Cadets

10.205 Anton Cornelissen referred to another investigation into the alleged abuse of Sea Cadets. He discovered that an officer within the Cadets was widely known as "Petty Officer Pervert". He thought that DI André Bonjour, a senior officer in the Cadets, must have known of this nickname but that he had failed to report any concerns to the FPT. In evidence, however, Anton Cornelissen said that he could not be sure whether in fact DI André Bonjour did know of the nickname.[150] André Bonjour told the Inquiry that in relation to the Paul Every investigation and the subsequent 2007 investigation into the Sea Cadets he declared his long-standing involvement with the organisation. He made clear to senior officers that he could have no role within the Police investigation. An email from André Bonjour to Police Legal Adviser Laurence O'Donnell dated 22 June 2007 confirms the stance he took at that time.[151]

Findings: Victoria College, Paul Every, Sea Cadets

10.206 The Victoria College allegations against Mr Jervis-Dykes were investigated, albeit some years after they could have been initially investigated. We have considered whether the conduct of DS Pryke could be said to amount to evidence of a cover-up and have concluded that it could not; we accept that DS Pryke, usually a conscientious officer, was badly affected by the serious illness from which he was suffering. DS Pryke did not close down the investigation which was a recommendation that he could have made. The investigation proceeded and concluded with the conviction of Mr Jervis Dykes.

[150] Day 102/94; WS000644/27/69
[151] Day 109/126; WD008384

10.207 We have not been shown any evidence of an attempt to cover up sexual offending by Paul Every or by any Sea Cadet officer, or of any attempts to impede those investigations.

Events leading to the commencement of Operation Rectangle

10.208 Operation Rectangle was the name given in June 2007 to the SOJP investigation into allegations of historical abuse of children in Jersey. The investigation was initially covert but its existence was made public in November 2007.

10.209 Having worked on the investigations into WN264 and Thomas Hamon, DC Brian Carter began to wonder whether there was a connection between the two and whether unauthorised individuals had gained access to children at HDLG. In 2006 he discussed with DI Peter Hewlett his concerns that there might be a bigger problem than Police had thus far realised.

10.210 Peter Hewlett told the Inquiry that the Thomas Hamon case was "*the tipping point*" when put together with information provided over the years by other Police officers. The SOJP needed to investigate HDLG or, in his opinion, the complaints would keep coming and never go away.[152]

10.211 Peter Hewlett and Brian Carter drafted a scoping report, following the outline for such a report suggested by the ACPO Guideline on investigation into historical child abuse. The report, dated 8 April 2006, was submitted to DCI André Bonjour, the DCI of Crime Services.[153] The report stated that "*rumours have been rife within the island for many years that Haut de la Garenne was notorious for the sexual, emotional and physical abuse allegedly handed out to residents*". It was envisaged that any investigation would initially concentrate on HDLG with the potential to involve other homes. The officers received no response. Peter Hewlett asked for a meeting with DCI André Bonjour and at that meeting André Bonjour was generally supportive according to Peter Hewlett. He said that he did not have the authority to make a decision on his own and would refer the matter to the senior management team.

[152] Day 104/117/118
[153] WS00647/16–19; WD008328/8, DS Peter Hewlett's report

10.212 André Bonjour's evidence to the Inquiry was that both he and John Pearson, Head of Operations, had concluded that what was being proposed was a "*fishing expedition*" and that the report did not justify a wider investigation. There were no named victims and no formal complaint to be investigated. He did not regard the report as a proper scoping report. André Bonjour did not request any further details, nor did he tell Peter Hewlett that no investigation was to be pursued.[154]

10.213 André Bonjour said that he did not ask for further information because John Pearson, Head of Operations, made the decision that there was to be no investigation and, as far as he was concerned, that was the end of the matter.

10.214 In July 2007, Lenny Harper asked for a meeting with Peter Hewlett and Brian Carter to discuss their report. It was Peter Hewlett's opinion that there should be an investigation into HDLG.[155] Lenny Harper and Graham Power agreed that André Bonjour's conduct should be investigated by another Police service; South Yorkshire Police were asked to advise on whether André Bonjour should be prosecuted for misconduct in public office.[156] John Pearson, in a witness statement made to the Inquiry, said that he knew nothing about the scoping report until Lenny Harper asked him in 2007 or 2008 (after his retirement) whether he would cooperate in the South Yorkshire Police investigation. He saw the report for the first time when South Yorkshire Police showed it to him.[157] In his view it did not contain sufficient detail to be regarded as a proper scoping report, but it did contain enough information to allow further enquiries to be made. He said that the matters raised should have been investigated fully.[158]

10.215 John Pearson declined to give oral evidence to the Inquiry. He no longer resides in Jersey and therefore could not be compelled to attend. He said in his statement to the Inquiry:

[154] Day 104/137–140
[155] Day 104/143
[156] Day 107/40
[157] WS000685/8
[158] WS000685/10–15

> *"Whilst I cannot explain Mr Bonjour's version of events, I do not think he has intentionally acted corruptly or attempted to cover anything up – I can only put it down to some mistake or misunderstanding. I always considered Mr Bonjour to be an excellent officer and I never had any cause to question his integrity. He had demonstrated his honesty at the time of the investigation into Paul Every of the Sea Cadets … He had a connection with the Sea Cadets and that he should not be involved due to a conflict of interest."*[159][160]

10.216 André Bonjour was also alleged to have failed to pursue an alleged link between retired DCI John de la Haye and suspected child abusers. André Bonjour was asked in evidence to the Inquiry about this allegation. He said that he told DI Alison Fossey to follow-up the suggestion of a link and trusted DI Alison Fossey and those under her command to carry out the investigation properly.[161]

10.217 In November 2008, John Edmonds, Director of the Criminal Division of the LOD, advised the Attorney General on the question of whether André Bonjour should be prosecuted for misconduct in public office in respect of either of these two alleged failures. The independent South Yorkshire Police report had concluded that "*there is insufficient evidence upon which to base a prosecution in respect of any criminal matter*". John Edmonds, in a memorandum to the Attorney General set out the allegations against André Bonjour.[162]

10.218 In respect of the "scoping report" John Edmonds noted that it was common ground that no action was taken in relation to the report. He wrote to the Attorney General on 17 November 2008:

> *"There is a strong inference that Andre Bonjour filed the report in his "too difficult to deal with" tray and by the time at which former DCO Harper started to investigate the matter there was no trace of the original report … I am not satisfied that we could ever prove to the criminal standard that Andre Bonjour had sat on the report … Regrettably I am afraid that it is probably a fairly typical example of the Police deciding for a combination of reasons not to grasp a potentially painful nettle."*[163]

[159] WS000685/13
[160] We consider below the investigation into offences alleged to have been committed by Paul Every
[161] Day 109/152
[162] WD009000/33
[163] WD009000/34

10.219 John Edmonds concluded that André Bonjour's conduct fell short of the conduct required for a criminal offence to have been committed. However he advised that the Police be invited to consider disciplinary action.[164]

10.220 The South Yorkshire Police report had recommended that André Bonjour's conduct be dealt with as an internal disciplinary issue rather than by way of prosecution. Although apparently drafted using the **Association of Chief Police Officers** (ACPO) guidelines, the Hewlett/Carter report provided insufficient detail to be a proper scoping report. On the other hand, it did provide sufficient information to warrant an urgent response.

10.221 We consider that this was an inadequate response by the SOJP to allegations of abuse. However, we are not satisfied that any actions were taken deliberately to obstruct the investigation of abuse.

Additional factors leading to the establishment of Operation Rectangle

10.222 Graham Power said that, in his opinion, the following led to the establishment of Operation Rectangle:

- the Paul Every case;
- the potential link between a suspect and a retired Police inspector;
- the Victoria College investigations;
- the public perception that, in the past, child abuse had been covered up in order to protect senior figures.[165]

10.223 In mid-2007, a SCR was published involving a child (not a child in care) who had been subjected to sexual abuse. DCI Alison Fossey said that it was, in her opinion, the SCR that caused Lenny Harper to pursue the investigation of child abuse.[166]

10.224 Lenny Harper referred in his evidence to the cases cited above. He said that it was his impression that while there was no organised paedophile ring in

[164] WD009000/34
[165] Day 107/44
[166] Day 118/2; WS000687/22

Jersey there was *"a loose arrangement and more widespread than a single ring … It was endemic through certain parts of Jersey society".*[167]

Finding: the decision to set up Operation Rectangle

10.225 In response to Term of Reference 12, we are quite satisfied that the concerns referred to above more than justified the decision in 2007 to set up Operation Rectangle.

10.226 The evidence indicates that an emerging picture developed in 2007, against the background of the investigations into allegations against Thomas Hamon and WN264 and the Victoria College scandal. The Paul Every case (involving Sea Cadets) would inevitably have attracted the attention of the public as well as senior Police officers. The allegation of a link between offences (by different offenders) against a Sea Cadet and a retired Police officer would clearly have been disturbing. Graham Power gave evidence of a perception that offences by senior figures in Jersey may have been covered up. Then, by July 2007 at the latest, Lenny Harper became aware of the scoping report and of the fact that nothing had been done in response to it. The SOJP were aware by mid-2007 of a number of apparently unconnected offences or alleged offences against children, said to involve people in influential positions who had easy access to children. There was evidence of past as well as more recent abuse. In those circumstances, the instigation of an operation to look for any links between these offences and/or to determine whether there were other offenders who had preyed on vulnerable children was clearly justified.

Initial leadership of Operation Rectangle

10.227 DI Alison Fossey was initially the SIO of the historic abuse inquiry. Professional Standards issues soon arose, such as when a SOJP officer was a potential suspect. Lenny Harper, as DCO, had to investigate professional standards issues and the decision was therefore taken to merge the criminal and professional investigations and for DCO Lenny Harper to become the SIO, with DI Alison Fossey as his deputy. Lenny Harper was an

[167] Day 121/105

experienced Police officer and had a reputation as a highly skilled investigator but did not have recent criminal investigation experience. He had assistance from Devon and Cornwall Police in the use of the HOLMES system. Alison Fossey had been trained as a SIO. Graham Power said that he recognised that, despite the experience of DCO Lenny Harper and DI Fossey, senior detective assistance would be needed and so sought UK experts to provide guidance. Andy Baker, Deputy Director of the Serious Organised Crime Agency, headed the ACPO team that provided that guidance.[168]

10.228 Lenny Harper explained in evidence that the covert phase initially concerned investigations into offending within the Sea Cadets. As files relating to incidents at HDLG were considered, and Police officers began to report their past requests for an investigation into events there, the operation developed a new context. Lenny Harper said that he wanted to maintain a small, tight team to reduce the risk of leaks to possible suspects. He was also concerned, he said, about interference from politicians.

10.229 Lenny Harper's concerns were clearly a factor influencing the setting up of the covert stage of Operation Rectangle. On the question of the possibility of political involvement during the covert stage, we are mindful of the evidence of Graham Power. He said that throughout this stage he provided briefings to the Minister for Home Affairs (Senator Kinnard), the Chief Minister (Frank Walker) and the States Chief Executive Officer (CEO) (Bill Ogley).

10.230 It was his impression that the politicians had not grasped the importance of the investigation. They were not overtly hostile, but did not appear to have any sense of urgency in the need to have a plan. He warned them when the operation was about to be made public and urged them to have a plan to deal with media interest.[169] This communication between the Chief Officer and senior members of government was clearly necessary; those with ministerial and administrative responsibility for policing, and the Police budget, obviously had to be briefed on the operation, and had to be in a position to deal with media attention. Our understanding is that the briefings

[168] Day 107/2; Day 121/73ff
[169] Day 107/45

were, appropriately, initiated by Graham Power, and we do not regard the contact as amounting to political interference.

Public phase of Operation Rectangle: allegations of cover-up

10.231 The Police made Operation Rectangle public in November 2007, when they learned that Senator Stuart Syvret had invited the BBC's Panorama team to Jersey to make a programme about historical child abuse. Senator Stuart Syvret, the Minister for HSS, was known as a champion of abuse victims but the SOJP had not told him of the detail of the covert operation.[170]

10.232 The SOJP provided a draft press release to the Chief Minister, the Chief Executive and to Senator Stuart Syvret the night before they intended to announce the existence of Operation Rectangle. Senator Stuart Syvret pre-empted that announcement by issuing his own press statement that night.[171]

10.233 The Police draft press release referred to "*victims*" of abuse. Bill Ogley suggested that the term implied that offences had definitely been committed. Lenny Harper was unwilling to make any amendments and, according to Lenny Harper, Bill Ogley said that reference to "*victims*" would be bad for Jersey's reputation. He told the Inquiry that he was under no illusion (after the meeting on 22 November 2007) that Frank Walker and Bill Ogley did not want an historical child abuse investigation. They told him that it would bring down Jersey's government.[172]

10.234 Frank Walker denied that he or Bill Ogley had made such a statement. He said that while he and Bill Ogley were unhappy about the fact that an investigation was needed, that did not mean they were opposed to one taking place.[173] Bill Ogley said that his understanding of Ministers' views and in particular, the view of the Chief Minister, was that the whole purpose of Operation Rectangle was: "*to ensure that guilty people were prosecuted and brought to justice and nothing must stand in the way*".[174]

[170] Day 121/120; WD008334/239
[171] Day 121/125
[172] Day 121/154
[173] Day 123/83
[174] Day 129/44

10.235 Once the existence of Operation Rectangle had become public, Ministers stated that there had been no cover-up and that the investigation must be allowed to take its course. Graham Power said that some political figures were supportive, some gave "critical friend" support and that Frank Walker and others visited HDLG and gave words of support. However, he also told the Inquiry that Senator Wendy Kinnard was telling him that there was a difference between public statements of support and what colleagues were saying privately; in private they were hostile to the investigation and said they wanted to bring it to an end.[175] Lenny Harper gave evidence to similar effect.[176]

10.236 Keith Walker said that he gave unequivocal support to the investigation although he recognised that one of his Ministers (Senator Ben Shenton) did not. In emails to Ministers and States members he made it very clear: "*let the Police get on with the job, you must not interfere with the Police investigation.*"[177]

10.237 The Attorney General, William Bailhache QC, told Graham Power that he had heard of the allegation of cover-up and requested that any investigation be conducted by an external Police service. Graham Power's response was that it was for him to decide whether an external Police service should be involved and that, in any event, no decision had yet been taken as to whether there should be a criminal investigation (into any alleged cover-up). Graham Power explained to the Inquiry that there was no question of the Attorney General seeking to discourage an investigation; the Attorney General wanted one that was demonstrably independent.[178]

10.238 Graham Power took advice from the Solicitor General, Timothy Le Cocq QC. The Victoria College and Maguire files and some further randomly selected files in child abuse cases (in which no action had been taken) were sent to Advocate MacRae to advise whether decisions had been taken properly. Advocate MacRae was a Jersey lawyer, then in private practice and independent of the Law Officers (and the SOJP). As a further check,

[175] Day 107/37
[176] Day 121/156ff
[177] Day 123/84
[178] Day 107/52

Advocate MacRae would, in respect of the randomly selected files and the Maguire case, also obtain the opinion of a barrister based in England.

10.239 Advocate MacRae concluded that any differences in view between the reviewers and those who made the original decisions were within the range of normal judgment or discretion. In the Victoria College case, he advised that it would have been legitimate at the time of the investigation for the prosecution of others to be considered, but that it was now too late to do so.[179]

10.240 Graham Power concluded that there was no basis for a criminal investigation into any cover-up in relation to past decisions. He told the Inquiry that, with hindsight, he realised that he had asked Advocate MacRae for an opinion based on the files that were available in each case. He had not asked for a view on whether the content of the files was adequate, nor had he (or anyone) considered whether the Police investigation – rather than the ultimate decision on prosecution – was flawed.[180]

10.241 We accept that both the Attorney General and CO Graham Power acted in good faith in their approach to the allegations of past cover-up. We believe that Graham Power acted appropriately in seeking independent legal opinion, and that he made a reasonable decision – not to conduct a criminal investigation – on the basis of the material available to him. Graham Power himself acknowledged to us the limitations of the material, in that he did not have any evidence as to the adequacy of the initial Police investigation. However, we consider that he made reasonable and proportionate efforts to identify any failings in the investigation and ultimate decisions not to prosecute. We consider that, had there been any suspicious failures in the investigations, such as avenues of investigation not pursued, or difficult questions not asked of suspects, the lawyers who considered the case files (at the review stage) would have spotted at least some of them.

[179] WS000536/67
[180] Day 107/54–55

Political involvement in Operation Rectangle

10.242 In mid-2007, while Operation Rectangle was still covert, Senator Stuart Syvret raised concerns following publication of a SCR into the case of a child who had been subjected to sexual abuse. He was critical of the review itself and of the failings it revealed, particularly within the HSSD. He was critical of the performance of his own department (of which he had been in charge for eight years) and other agencies.

10.243 Frank Walker said that the Council of Ministers' initial response was to seek to establish the true position at the HSSD. A three stage plan was created and the first two stages implemented quickly: first, departments were to liaise more closely, and secondly there was to be an independent review of child care [Andrew Williamson was appointed to conduct the review]. The third stage of the plan was a public Inquiry.[181]

10.244 In his evidence to us, Frank Walker accepted that the criticisms made in the serious case review provided some support for Senator Stuart Syvret's claims but said that they did not justify Senator Stuart Syvret's assertion of failings on such a fundamental scale.[182]

10.245 He said that Senator Stuart Syvret made inappropriate public attacks on civil servants and continued to make unsubstantiated claims in respect of child welfare failings.[183]

10.246 On 25 July 2007, a meeting of the Corporate Management Board and a meeting of the Child Protection Committee took place at the same time. After the meeting of the full Board, Bill Ogley asked representatives of agencies who dealt with child welfare to stay behind. Graham Power told the Inquiry that Bill Ogley then explained to the heads of the relevant agencies that the Chief Minister wished to get rid of Senator Stuart Syvret. He wanted their support because a vote of no confidence at the Council of Ministers might be contentious. Graham Power declined to take part on the basis that the SOJP

[181] Day 123/78
[182] Day 123/70
[183] WD008868/84

should be politically neutral. Bill Ogley then asked him to leave the meeting.[184]

10.247 Bill Ogley's evidence to the Inquiry was that he wanted to know whether Senator Stuart Syvret's conduct was having a detrimental effect on those departments. He was not seeking to influence the Chief Officers' views.[185]

10.248 The other Chief Officers stayed, but did not want their views conveyed to Ministers on what they regarded as a political issue. Bill Ogley told the Inquiry that their views were not in any event of sufficient concern in aggregate to be reported: *"They (the concerns) were being dealt within individual departments and within the remit of the States Employment Board."*

10.249 At the Child Protection Committee meeting, DCI Alison Fossey was also asked to participate in a vote of no confidence but declined to do so. She then left the meeting, and we have no further evidence of discussions at the meeting on that topic. The minutes of the meeting contained no reference to this vote, and it appears that they were not circulated. The minutes of the following meeting of this Committee contain no reference to the minutes of the meeting of 25 July 2007.

10.250 Frank Walker told the Inquiry that there was nothing odd about the same issue being raised at both of these meetings; it was the key political issue of the time.[186] Wendy Kinnard believed that the meetings had been orchestrated and that the civil servants had intervened inappropriately in a political matter.[187] We have no doubt that the meetings had been orchestrated; it would be extraordinary if at two meetings, held at exactly the same time, a vote of no confidence in Senator Stuart Syvret had been called entirely by coincidence. We do not have evidence from which we could conclude that the civil servants who attended the meetings behaved inappropriately. It appears that those who attended the Chief Officers' meeting did not know in advance of the request that Bill Ogley was to make,

[184] WS000536/47/161; Day 107/23
[185] Day 129/17
[186] Day 123/58
[187] Day 135/20

and that they – entirely properly – declined to have conveyed to Ministers any criticisms that they might have of Senator Stuart Syvret.

10.251 On 27 July 2007, six of the 10 Ministers wrote a letter to Chief Minister Frank Walker calling for Senator Stuart Syvret to be dismissed as a Minister.[188]

10.252 Frank Walker told us that he tried to resolve matters with Senator Stuart Syvret, seeking to persuade him to apologise for his public attacks on civil servants (which were a breach of the Ministerial Code). He also tried to persuade Senator Stuart Syvret that the Council's proposed three stage approach provided the necessary independent and rigorous scrutiny of his claims. Reconciliation was impossible, said Frank Walker, and the Senator was removed from his post, the basis being his breaches of the Ministerial Code.[189]

10.253 Stuart Syvret continued to campaign against what he perceived to be failures to protect children and the covering up of abuse. It was the discovery that Stuart Syvret intended to give a BBC interview that caused the SOJP to make public the fact that Operation Rectangle had commenced.

10.254 Stuart Syvret maintained his active interest in Operation Rectangle and Lenny Harper said in evidence:

> *"Stuart Syvret was asking legitimate questions, making legitimate enquiries on behalf of … victims. Sometimes Stuart Syvret would make enquiries that I wouldn't think were legitimate and then I wouldn't give him the information … Stuart Syvret was coming in to incident rooms and sending emails all the time. There's no secret about it, they are all over the place. He was representing the interests of a number of victims and even if I hadn't wanted to speak to him, which I had no problem with, it would have been very difficult to avoid him. So there's nothing sinister …".*

10.255 Frank Walker asserted that Graham Power, Lenny Harper and Stuart Syvret colluded in a campaign to highlight corruption among Jersey's judiciary, politicians and lawyers. He accepted that they probably did genuinely believe corruption to exist but said that he had yet to see any evidence of it from any of them. He could not go as far as to say Graham Power wanted to bring

[188] WD008868/84
[189] Day 123/59

down Jersey's establishment but asked why, if he (Graham Power) believed there to be corruption he did not investigate it, being the person in Jersey best placed to do so.[190]

10.256 Stuart Syvret has not given evidence to this Public Inquiry. Requests to him were made on a number of occasions seeking his assistance and any relevant evidence he might have. As a States member for many years, latterly as the Minister for HSSD, his contribution to the work of this Inquiry may have assisted. His refusal to assist is to be regretted.

10.257 We conclude that, following publication of the SCR of a child subjected to sexual abuse Stuart Syvret highlighted relevant issues which needed to be addressed to ensure the protection and safety of children in Jersey. His actions did not amount to political interference with Operation Rectangle. Until November 2007, Operation Rectangle was covert, and Senator Stuart Syvret was unaware of it. He could not, therefore, have done anything with the intention of interfering with Operation Rectangle, or even being reckless or careless about whether he interfered with it.

10.258 His public attacks on civil servants were inappropriate and did not assist his cause. We accept that Frank Walker and Bill Ogley were genuinely troubled by his conduct in this respect, believing his behaviour to be incompatible with his duty as a Minister, and we do not believe that the moves to remove him were conducted with the intention of covering up child abuse. In those circumstances, further consideration of the reasons for, and manner of, his removal from post does not fall within our Terms of Reference.

10.259 Once Operation Rectangle had become overt, Senator Stuart Syvret took a close interest in the Police enquiry, attending the incident room and asking many questions. We accept Lenny Harper's evidence that some of the questions were legitimate, and that the Police simply refused to answer questions that were inappropriate. We do not conclude that Senator Stuart Syvret's involvement in the Police investigation amounted to political interference with Operation Rectangle.

[190] Day 123/138

Search of Haut de la Garenne and the response to it

10.260 The Inquiry is not required to determine whether policing decisions were right or wrong except in so far as those decisions have a direct relevance to the Terms of Reference. The key issues are:

- under Term of Reference 11, the response of the Police to the abuse allegations; and
- under Term of Reference 13, the process by which Police files were submitted to the prosecuting authorities, and the way in which decisions whether to prosecute were made.

10.261 A great deal of media attention was generated by the SOJP press statement dated 24 February 2008, which included the assertion that "*the partial remains of what is believed to have been a child*" had been found at HDLG. Subsequent scientific analysis revealed that the item believed at that time to be part of a child's skull was not human bone and was probably coconut shell. Graham Power agreed that making the assertion quoted above in the press statement was "*not good*".[191]

10.262 In fairness to Graham Power, we should note that he went on to say that there were leaks from the investigation (to the media) and that there was no possibility of keeping secret the fact that a significant find had been made. He emphasised that the Home Office scientist at the scene had said that the item was a piece of a child's skull.[192]

10.263 Graham Power acknowledged in his witness statement to the Inquiry that, when Lenny Harper referred in his press release to "*the potential remains of a child*" having been found, his words were "*insufficiently precise*", not because they were untrue (because at the time they were believed to be true) but because they were capable of wider interpretation than would be justified through the discovery of a single fragment of bone. However, as Graham Power pointed out, if part of a child's skull had been discovered, then that child must be dead.[193] When asked in evidence about media

[191] Day 107/74
[192] Day 107/75
[193] WS000536/85

reporting, Graham Power drew a legitimate distinction between the information actually provided by the Police to the press and the exaggerated reporting that followed. When asked whether more should have been done to correct inaccurate press reporting Graham Power conceded that "*of course*" it should have been.[194]

10.264 The SOJP at this stage issued press releases almost daily. Jersey became a focus of media attention with frequently lurid headlines in the national and international press. This attention inevitably caused concern to many Jersey politicians. Frank Walker said that "*the island went into complete sho*ck" and referred to a church service held by the Anglican Dean of Jersey to commemorate and pray for those children believed to have been murdered.[195]

10.265 Michael Gradwell, who joined the Operation Rectangle team as its SIO in September 2008, told the Inquiry that he had no criticism of Graham Power for treating HDLG as a potential homicide scene at a time when the fragment was thought to be human bone.[196]

10.266 In an email dated 26 February 2008, Bill Ogley wrote to Graham Power and the Attorney General, William Bailhache QC, making clear his view that there should be no further comment about the investigation by the Chief Minister, Frank Walker, or on Ministers' behalf:

> *"the only way to get to the bottom of it is to let the Police enquiry run its course and ensure that any prosecutions are successful".*[197]

10.267 Bill Ogley suggested that he, Graham Power, and the Attorney General hold a press conference to explain that continued media speculation might jeopardise fair trials and therefore there would be no political comment. Graham Power opposed the idea of a joint press conference:

> *"… my feeling about what you propose is that we reinforce remaining suspicions that we are all part of a senior 'club' as opposed to what I see as the correct situation … we each head separate entities which*

[194] Day 107/86
[195] WS000697/19
[196] Day 111/58
[197] WD007170/332

> *are powerful in their own way but are controlled by a system of checks and balances".*[198]

10.268 The Inquiry has seen correspondence and notes of meetings involving politicians, the Attorney General, Graham Power and Lenny Harper in which the Attorney General urged politicians not to intervene. He also sought to persuade the SOJP to correct inaccurate reporting. The Attorney General stated repeatedly his concern about the effect of publicity on any prosecutions. Politicians, especially Senator Ben Shenton, expressed their concern about the effect of this publicity on the reputation of the island. On 2 March 2008, Senator Ben Shenton wrote to Senator Wendy Kinnard, complaining of the publicity and speculation surrounding the discovery of the piece of "bone" and asked: *"Why have you allowed your Ministry to be run in such an unprofessional and shameful manner?"*[199]

10.269 On the same day, the Attorney General sent an email to the Council of Ministers:

> *"This is not the time to have any more public comments or spats about why things have happened as they have. Can we please let the justice issue be dealt with by the justice agencies or there stands the risk that there will be even more damage done to the victims of crime, to the accused and to the witnesses called to give evidence, and thus to the island's credibility as being able to manage its own processes."*[200]

10.270 CO Graham Power clearly felt that he was under unacceptable political pressure. Having seen Senator Ben Shenton's email, he wrote to the Chief Minister, stating:

> *" … I regard the contents of the email with concern. It is defamatory, inaccurate, and most seriously is capable of being read as an attempt to undermine the investigation. It has already consumed resources which could have been better used. It is of course a document which could be disclosed in any future prosecution process.*
>
> *I feel that as Chief Officer of Police it is now the time for me to state clearly that this type of interference should cease. On a daily basis we are asked if there has been any political interference in the case. Yesterday we said 'no'. It is probable that tomorrow we will still be able to justify saying 'no'. However, if there are any more actions of this nature which appear to me intended to undermine the investigation or*

[198] WD007170/331
[199] WD008204/5
[200] Day 123/166

> *its key participants I will regard that as unacceptable and consequences will follow …"*[201]

10.271 On 3 March 2008, Frank Walker sent an email to the members of the Council of Ministers:

> *"Dear all, I am aware that there is disquiet about some of the media statements issued by the Police in relation to discoveries at Haut de la Garenne and serious questions have been put to Wendy. Although I reiterate my belief that those questions need to be answered, at the right time, I also repeat my previous statements that now is most definitely not the time. I have received further information today that makes it clear that any approaches to the Police, questioning or public statements will be regarded as interfering with the investigation and likely to be publicly disclosed. That is unthinkable and would put the minister concerned in an untenable position. I need to make it clear that any minister who fails to follow the correct procedures, and who may be responsible directly or indirectly for any suggestion of interference, will be on his/her own and will be exposed as such."*[202]

10.272 Graham Power arranged for members of Andy Baker's ACPO team to meet ministers in his, Graham Power's, absence, so that ministers could raise, and the ACPO team address, any concerns that politicians had about the professional standards of the investigation. One such meeting took place on 7 March 2008. Senator Wendy Kinnard told the Inquiry that there were two or three ACPO meetings, during which members of the ACPO team made some recommendations but no substantive criticisms.[203]

10.273 On 27 March 2008, in a televised meeting of the Council of Ministers, the proposal to set up a Public Inquiry was announced. It was said that no enquiry could take place until the completion of any criminal proceedings.[204]

10.274 On 31 March 2008, Frank Walker and his wife visited the scene of the Police operations at HDLG. Lenny Harper told them that new forensic evidence indicated that no murders had taken place. Frank Walker was relieved and said he awaited a public announcement from the SOJP. When no such announcement was made he discussed the situation with the Home Affairs

[201] WD8204/6
[202] WD008868/240
[203] WD008190, Day 135/79
[204] Day 123/143

Minister (Wendy Kinnard). They decided that it would be wrong to seek to interfere.[205]

10.275 On 18 April 2008, the SOJP issued a press statement in respect of the "*fragment of skull*" found at HDLG the previous February. They said that it was not possible to date the item but it was unlikely that a formal homicide investigation would be instigated in relation to the bone alone. The site: "*must remain the scene of a possible homicide*" until such time as the excavations were complete. A number of bloodstained items had been found in two of the cellars but it was not known whether there was an innocent explanation for these items.[206]

10.276 On 2 May 2008, Lenny Harper sent an email to Frank Walker, Bill Ogley and Wendy Kinnard. He said that, in the previous week, two children's milk teeth and a number of bone fragments had been recovered. Initial forensic examination indicated that the child had died no earlier than the 1950s. Confirmation by carbon dating would mean that a homicide enquiry would have to be launched. This information was subsequently made public.[207]

Political response to the continuing Operation Rectangle investigation

10.277 On 20 May 2008, Frank Walker wrote to Senator Wendy Kinnard (Home Affairs Minister), saying:

> *"I … have been counselling people all day not to jump to conclusions, to await the further results from the lab, and not to forget that there is an ongoing investigation into the most serious allegations of child abuse which has to be supported and which has to be able to arrive at a full and proper conclusion. I have also robustly dismissed calls for your resignation and Mr Harper's suspension."*[208]

10.278 Frank Walker denied that he had sought to bully Senator Wendy Kinnard, either through this email or at any other time.[209] Senator Wendy Kinnard said that she had not known at the time of any calls for her resignation; she was

[205] Day 123/139
[206] WD007174/2
[207] WD008868/230
[208] WD008868/259
[209] Day 124/23

away from the island. She felt intimidated by the email, while recognising that the email did appear to offer Frank Walker's support.[210]

10.279 Senator Wendy Kinnard told the Inquiry that Frank Walker never said that he had ceased to support the investigation: *"It was much subtler."* She believed, however, that the Council of Ministers, as they became increasingly exercised about the effects on Jersey of bad publicity, ceased to support Operation Rectangle, while acknowledging that they were *"stuck with it".*[211]

10.280 She said that, up until May 2008 (when, for legal reasons, she ceased to be involved in Operation Rectangle), the Council made *"decent"* decisions relating to the investigation. She did not believe that Ministers wanted to cover up abuse; they just wanted the issue to go away and one way of achieving that was "*to minimise it in their own minds*".[212]

10.281 On 23 May 2008, Senator Wendy Kinnard had a meeting with Frank Walker at which (on the advice of the Attorney General) she explained that she was going to cease to have oversight of Operation Rectangle. Her evidence was that Frank Walker behaved in a bullying manner and said that he was no longer sure that she should remain a Minister at all. She also recalled Bill Ogley saying at that meeting (which was also attended by Graham Power) that Lenny Harper should be removed. On being told by Graham Power that that was not going to happen, Bill Ogley said to Senator Wendy Kinnard: "*Well, if you don't remove the Deputy Chief, then there's always the case of considering removing the Chief.*"[213]

10.282 Graham Power's view was that politicians and those in government were willing to cover up child abuse in order to protect Jersey's reputation. Frank Walker and Bill Ogley told him that Operation Rectangle was damaging Jersey's reputation. He told them that the only way to respond to the abuse allegations was to investigate them fully and that Jersey's reputation would be enhanced by a thorough enquiry.[214]

[210] Day 135/134
[211] Day 135/67
[212] Day 135/69
[213] Day 135/143–149
[214] Day 107/38

10.283 Graham Power told the Inquiry that he was not prepared to discuss Police investigations with States members. The questioning in respect of Operation Rectangle was "*quite nasty, quite aggressive and hostile*".[215]

10.284 It became public knowledge that the Director of Education at the time, Mario Lundy,[216] was suspected of the physical abuse of children. Graham Power said that, at a meeting attended by himself, Bill Ogley and Mario Lundy, Bill Ogley said: "*If anyone wants to get Mario they will have to get me first.*" Graham Power said that the statement was met with applause by some of those present and he took this incident as indicating the closing of ranks by the "in crowd" against the "threat" of Operation Rectangle.[217]

10.285 Frank Walker said in his statement to the Inquiry that he was committed to ensuring that the Police investigation progressed without hindrance. He identified four statements of intent that he developed:

- no stone would be left unturned to enable the Police to investigate and bring to justice anyone who had abused a child or had, by their silence or otherwise, aided and abetted such abuse;
- there would be no constraints on the Police budget in their investigation into child abuse;
- victims would be given every possible support;
- there would be a totally independent Public Inquiry into historic abuse where the island had failed to protect vulnerable children. Painful lessons had to be learned.[218]

10.286 Frank Walker told the Inquiry that he was concerned about Graham Power's apparent inability to control Lenny Harper. When he suggested that Graham Power (not Lenny Harper) should do the press conferences, he was astonished by Graham Power's refusal and his stated wish not to upset Lenny Harper. Frank Walker concluded that Graham Power was unable to stand up to Lenny Harper.[219]

[215] Day 107/72
[216] Former Principal at Les Chênes
[217] WS000536/71/237; Day 107/65
[218] WS000697/22
[219] Day 123/154

10.287 The public perception at that time was, we believe, succinctly dealt with in the submissions to this Inquiry by the JCLA:

> *"It would be wrong and misleading to suggest that any of the politicians condoned child abuse, but the stance they adopted led to a rapid polarisation between those who wanted aggressively to pursue the investigation and those who had concerns for Jersey's reputation. Some politicians wanted to have it both ways which only seemed to compound the problem which was being created, that is, a breakdown in trust."*

Sir Philip Bailhache's Liberation Day speech: May 2008

10.288 On 9 May 2008, the Bailiff, Sir Philip Bailhache, made the Liberation Day speech, which included the statement:

> "*all child abuse, wherever it happens, is scandalous, but it is the unjustified and remorseless denigration of Jersey and her people that is the real scandal".*

10.289 In his evidence to the Inquiry, Sir Philip said that he had considered "*in the round*" the effect that his speech would have but had not considered in particular the impact that his words "*but it is the unjustified and remorseless denigration of Jersey and her people that is the real scandal"* might have on the victims of abuse. He said that it was a "*false reading*" of the passage to interpret it as suggesting that child abuse investigations came second to respect for the island. He was not seeking to minimise the gravity of any child abuse. He also said that he felt that Lenny Harper was deliberately feeding information to the media with a view to achieving sensational headlines and that he "*would not have been disappointed*" had Lenny Harper taken his comments as a reflection on the way in which the investigation was being conducted.[220]

10.290 Sir Philip said that perhaps his juxtaposition of words was unfortunate. He accepted that as a highly experienced lawyer he was accustomed to choosing words carefully. His purpose was to address the island as a whole and encourage Jersey people not to feel ashamed of their history. The

[220] Day 125/94

apparent comparison between the importance of child abuse and Jersey's reputation did not occur to him.[221]

10.291 We have considered whether Sir Philip's words indicated a belief on his part that the reputation of Jersey was of more importance than the child abuse investigation. We cannot accept that a politician and lawyer of his experience would inadvertently have made such an "*unfortunate juxtaposition*". We are sure that the way in which Jersey is perceived internationally matters greatly to him. However, his linking of Jersey's reputation to the child abuse investigation was, we are satisfied, a serious political error, rather than a considered attempt to influence the course of the Police investigation.

10.292 John Edmonds, a senior member of the LOD, described the atmosphere in Jersey at the time of his arrival from England in June 2008:

> *"… quite a febrile atmosphere in Jersey, that the issue of the historic child abuse investigation was all pervading, all consuming and it was quite clear that in terms of the history of Jersey this was quite a major incident … there was already significant media attention … in the national media … and also in the international media. It had been on Newsnight, there had been a Law in Action programme: Jersey was very much in the spotlight".*[222]

Findings: actions of agencies of government and politicians

10.293 We are required, under Term of Reference 9, to review the actions of the agencies of government and politicians, particularly when concerns about child abuse came to light. We are also required under Term of Reference 13 to consider whether the process under which the SOJP submitted files to prosecutors was subject to any political or other interference. Clearly, any interference with the underlying investigation into child abuse would have an effect on the ability of the Police to submit files to prosecutors.

10.294 It is clear that there was disquiet among Jersey's politicians, up to and including the Chief Minister, Frank Walker, about the effect of the publicity being generated by Operation Rectangle. Nevertheless, we find that Frank Walker and the majority of politicians accepted the strong advice of the

[221] Day 125/99
[222] Day 126/21–22

Attorney General and did not seek actively to interfere. We find that Ministers in general recognised that, however unpalatable the outcome of Operation Rectangle might prove to be, the Police investigation had to be permitted to run its course unhindered. The alternative, leading to public accusations of cover-up, would have been far worse for Jersey's reputation, and we find that politicians recognised that fact.

10.295 Nevertheless, we accept that CO Graham Power would have felt under pressure from the public opposition voiced by Senator Ben Shenton and others. In addition, he was placed under some pressure by Frank Walker and Bill Ogley, who told the Inquiry that they raised questions with him about Police media handling, and also criticised the conduct of DCO Lenny Harper. The questions raised by Frank Walker and Bill Ogley undoubtedly reflected genuine concerns, and from their point of view had a legitimate basis, but the effect of constant questioning was inevitably to lead Graham Power to perceive that he did not in reality enjoy the political support that was being asserted in public.

Relationship between Operation Rectangle team and the Law Officers

10.296 There clearly were difficulties in the in the relationship between the SOJP and the LOD during the course of Operation Rectangle. The issue for us is the extent to which, if at all, the difficulties had an impact on the investigation and prosecution of cases of the abuse of children in care.

10.297 Graham Power told the Inquiry that a number of issues, in his opinion, impeded the development of a good working relationship between the Police investigation team and the Law Officers. We have summarised the principal issues below.

10.298 He said that there were perception issues arising from the fact that Jersey does not have an equivalent to England and Wales' independent Crown Prosecution Service. In Operation Rectangle, decisions as to the prosecution of government staff lay in the hands, he said, of those perceived to be the

"*government's lawyers*". This, he said, undermined the confidence in the investigation of some victims, witnesses and even Police officers.[223]

10.299 In his oral evidence he said that he was aware of the procedures put in place by the Attorney General for the review of Operation Rectangle cases, namely that decisions in the first instance would be made by Crown Advocates and cases referred to the Attorney General only if the Crown Advocates advised against prosecution. However, he said that he perceived the Attorney General and Crown Advocates as part of the same hierarchy. He emphasised that his principal concern was one of public perception. If the public thought that the government's lawyers were making decisions as to whether government employees should be prosecuted, they would not have faith in the system, even if the decisions were correct.[224]

10.300 Graham Power also said that another issue was a confusion as to the chain of command within the LOD and as to who was in a position to provide advice and decisions. He said that there were issues around the availability of Crown Advocate Steven Baker, who had been appointed to prosecute any Operation Rectangle cases, and said that there had been poor handling by Simon Thomas, the London barrister appointed by the Law Officers to assist the Police, of the initial relationship with the Police team. There had also been a specific disagreement between the Police and Simon Thomas as to the proposed prosecution of two individuals, WN279 and WN281.

10.301 Graham Power recalled there being a disagreement between him and the Attorney General over Graham Power's view that the way to deal with the public perception issue was for the Attorney General to appoint a high profile, specialist and independent "special prosecutor" to work with the Police. The Inquiry has seen a note dated 25 February 2008, made by the Attorney General, which recorded William Bailhache QC asking Graham Power whether he needed a lawyer to be attached to the investigation at that stage, and Graham Power replying that he would consult Lenny Harper. Graham Power told the Inquiry that he did not recall the offer being made, but did remember speaking to Lenny Harper and then asking the Attorney

[223] WS000536/97
[224] Day 107/133–4

General to provide a full-time dedicated lawyer, ideally from the UK, to assist the investigation.[225]

10.302 The Inquiry has seen an email written by Graham Power on 17 April 2008 to the Attorney General, accepting the offer of a lawyer with a specialist background in child abuse work to assist the Police. He said that the investigation had reached a point at which full time legal support was appropriate, and suggested that the lawyer should be accommodated at Police headquarters to facilitate meetings and consultations.[226] William Bailhache QC replied the following day, confirming the immediate appointment of Simon Thomas.

10.303 However, we are aware that the Simon Thomas did not work full time on Operation Rectangle and the fact that he was not always available when needed was a source of frustration to the Police. Further, he did not have the expertise in the prosecution of child abuse cases for which the Police had hoped. The appointment was not, therefore, the success for which both the Police and the Attorney General had hoped.

10.304 William Bailhache QC, then Attorney General, was concerned by the SOJP's media policy and met with Graham Power and Lenny Harper on 13 May 2008. His particular concern at that point was a recent article in the UK national press in which Lenny Harper had been quoted as saying that he had no evidence that the Attorney General was wilfully obstructing the investigation, although there had been some misunderstandings. Graham Harper was also quoted as saying that he had not accepted William Bailhache's advice to have a lawyer within the Police inquiry team office itself, because to have done so would be highly irregular. The note that William Bailhache made of the meeting makes clear that this newspaper article was the focus, at that time, of his dissatisfaction with the Police media strategy. The note records:

> *"LH denied he was briefing against me. He cdn't say I was not obstructing his enquiry because he had no evidence that this was so. I asked him if he believed I was. He said he did not.*

[225] WD008198/5, Day 107/92–93
[226] WD007534/16

> *He agrees it would have been better to say that it was unusual, rather than irregular, to have lawyers in Police HQ …*
>
> *GP said given lack of trust, perhaps I shd make statement. I said I was considering it.*
>
> *I said to LH if he had a problem, he shd tell me. He sd he wd but I am not confident that he meant it."*[227]

10.305 William Bailhache, in his witness statement to the Inquiry, said that, at that meeting:

> *"I made it clear to both of them that the way that the investigation was being managed in the press was a major cause for concern. It was liable to impact on the administration of criminal justice on the island and I advised both of them that whilst it was not my business how the Police ran their investigation, it became my business if it was impinging on the prosecution process. I understood the need for a media policy that encouraged complainants to come forward. I'm not critical of that at all … While it may have been sensible to use the media to combat any perception and encourage complainants to come forward, it was wrong to create an environment where there was a real risk of obtaining incorrect or false complaints or which would otherwise fuel abuse of process arguments."*[228]

10.306 This element of the discussion is not contained within William Bailhache's detailed note of the meeting. While it is undoubtedly true that William Bailhache raised the issue of the Police's media policy with Graham Power on a number of occasions, it seems to us likely that at this particular meeting he concentrated principally on the criticisms made of him in the recent article, and on the related issue of whether he should distance himself from the prosecutions, rather than on wider issues.

10.307 William Bailhache QC acknowledged that there was a public perception that he was obstructing Operation Rectangle. Matters became very difficult after the Law Officers, advised by Simon Thomas, decided not to prosecute two individuals (WN279 and WN281). Lenny Harper issued an intemperate press release, criticising that decision. At a meeting on 25 June 2008 to discuss the decision not to prosecute the two individuals, the Attorney General demanded an explanation of the Police media policy and the reasons for issuing a press statement about the case. The record of the meeting states:

[227] WD008198/6
[228] WS000701/40

> *"The Police know that there are already allegations that the Attorney General is obstructing the investigation and this type of release serves only to add fuel to such allegations."*[229]

10.308 When asked in evidence to comment on this note, Graham Power said that the Attorney General was not obstructing the investigation but that he was not proactive in promoting it. Graham Power said that, in the UK, he had seen senior Crown Prosecutors go to the media and encourage victims and witnesses to come forward. He said that nothing similar was done by the prosecuting authorities during Operation Rectangle. Graham Power also said that no serious attempt was made by William Bailhache QC to address perception issues, and nothing was done to strengthen the belief of the public in the integrity of the justice system.[230]

10.309 Graham Power acknowledged that there had been difficulties on the Police side. Lenny Harper had become the public face of the investigation. He was approaching retirement; Graham Power was able to tell the Attorney General, in a telephone call on 26 June 2008, that Lenny Harper's replacement had already been appointed and that there would be a new senior investigating team within a few weeks. In that call, the Attorney General said that work needed to be done to improve the relationship between the Police and lawyers, and Graham Power said that it would be helpful to have a clear chain of command on the Law Officers' side. Both agreed on the need to work on the public's lack of trust of the legal system. The call appears to have been a constructive one on both sides.

Operation Rectangle under David Warcup and Michael Gradwell

10.310 Graham Power told the Inquiry that to have removed Lenny Harper for any reason other than his planned retirement would have been "*world news.*" He nevertheless opposed any suggestion that Lenny Harper should stay beyond his retirement date to continue with Operation Rectangle:

> *"I think given the difficulties we had had something of a relaunch with new faces was appropriate and I include myself in that. I thought that I could see the arguments for saying we ought to create a forward*

[229] WD008199
[230] Day 107/146

> *momentum with different people and lose the baggage, if you like, of all the difficulties that had gone before."*[231]

10.311 On 31 July 2008, Lenny Harper gave an interview to the BBC in which he stated:

> *"No matter how certain politicians in Jersey would like to attack us and no matter how they would like that to go away, the fact remains that we have found the remains of at least five children there (at Haut de la Garenne) and attempts have been made to burn these remains, attempts have been made to bury and hide them, so we can't get away from that, but at the end of the day there just might not be the evidence there to mount a homicide investigation."*[232]

10.312 David Warcup, formerly Deputy Chief Constable, Northumbria Police, was appointed in the summer of 2008 to the post of DCO of the SOJP. He made clear the need for a suitably experienced officer to be appointed to the role of SIO. Michael Gradwell, seconded from Lancashire Constabulary, took up that post on 8 September 2008.

10.313 There is uncontradicted evidence, from both Police officers and Law Officers, that the working relationship between the Law Officers' Department and Mr Warcup and Mr Gradwell was far better than the Law Officers' Department's relationship with Mr Harper.

10.314 David Warcup described the relationship between the Police and media at the time of his arrival as "*toxic … disruptive, it was unhelpful; it was challenging".* He was particularly critical of the willingness of some sections of the media to publish leaked material.[233]

10.315 DI Alison Fossey said that "*Gradwell and Warcup were anxious to set the record straight*".[234]

10.316 Graham Power told the Inquiry that he recognised that:

> *"there was absolutely no dispute over the need to do some clarification around the history of the media reporting".*[235]

[231] Day 107/162; WD00536/121
[232] Day 110/24
[233] Day 120/48
[234] WS000687/41
[235] Day 107/165

10.317 David Warcup told the Inquiry that the situation had been sensationalised by media reporting; there was a public perception that children might have been murdered and he needed to know the true position. He realised that leaked information indicating that the Police no longer thought that there had been murders had led to a negative reaction from members of the JCLA; there was a perception that the Police could not be trusted to investigate child abuse. He met representatives of the JCLA, seeking to allay concerns that matters would not be properly investigated or would be covered up. He encouraged witnesses to come forward and believed that a multi-agency approach was needed to establish the confidence of potential witnesses.[236]

10.318 He also gave an order that there would be no further press releases without his consent.[237]

10.319 Graham Power emphasised in his witness statement that he was not involved in the operational side of Operation Rectangle, save for the short period of the handover between Lenny Harper and David Warcup, and did not know all of its details. It was not his role to be so involved; his job was to run a Police force.[238] He told the Inquiry that Operation Rectangle was one of a number of major criminal investigations that were ongoing at the time. Further, he was not a detective by background. He recognised that he *"did not have either the training or the experience to pass judgment on the operational details of a major crime investigation*".[239]

10.320 He said that, at that time, he was involved in "*succession planning*" and, realising that he was losing control of Operation Rectangle, he told David Warcup that he would not stand in his way if David Warcup wanted a press conference.[240]

[236] Day 120/26
[237] Day 120/17
[238] WS00053671/75–76
[239] WS000536/77
[240] Day 107/171

10.321 David Warcup, on the other hand, thought that Graham Power was distancing himself from decisions that had to be made and he felt that Graham Power should have provided stronger leadership.[241]

10.322 By October 2008, there had been media reporting of the intention of the lawyers representing an alleged child abuser, Gordon Wateridge, to argue that press reporting of Operation Rectangle had made it impossible for Mr Wateridge to have a fair trial.[242] David Warcup told the Inquiry that his strategy was to hold a press conference at which the Police would clarify matters.[243]

10.323 The date of the press briefing was set, mindful of the timetable for the joint abuse of process applications made on behalf of the defendants Wateridge, Donnelly and Aubin. All of them faced charges of sexual offending against children. The lawyers applied to stay the proceedings against them on the basis they could not have fair trials because of the publicity concerning Operation Rectangle.

10.324 David Warcup said, in respect of the conduct of Operation Rectangle during his tenure:

> *"The intention was to ensure that every complaint and allegation was investigated to the point of prosecution or no further action."*[244]

10.325 When asked, during his evidence, whether that aim had been achieved, David Warcup replied:

> *"I think we did. I think we achieved that. We went a stage further as well … we never closed our mind to the fact that there could be further evidence out there … we looked at all matters in relation to outstanding missing persons … matters in relation to murders that were committed within the jurisdiction, the potential for any serial offending … and it did not happen … we did not find this … that just in case there were any previous incidents or serious crimes that had been committed in the island which we should have joined up with the current inquiry. So we attempted to do that … "*[245]

[241] Day 120/40
[242] WS000694/20
[243] Day 120/54–58
[244] WS000 0694/40/134
[245] Day 120/150

10.326 He added:

> *" … There wasn't any pressure not to prosecute or not to pursue with rigour any particular individuals, whether they were States employees, former States employees or anybody else for that matter."*[246]

Findings: the management of Operation Rectangle

10.327 It is clear that the relationship between the Operation Rectangle Police team and the Law Officers was poor almost from the outset, largely because of the lack of trust on the part of the Police in the ability of the Law Officers to make decisions that would be perceived by the public as fair and independent. Relations worsened substantially from February 2008, with the increasingly hysterical and inaccurate media reporting of the progress of the Police investigation. A crisis in the relationship occurred in July 2008, with the issuing by Lenny Harper of a press release, criticising the decision not to prosecute WN279 and WN281.

10.328 The mutual distrust in the working relationship undoubtedly caused problems in an investigation that was difficult in any event. The Police were investigating allegations of past abuse, which in some cases were alleged to have occurred many years in the past. Evidence of such abuse is, by very reason of the passage of time, often extremely difficult to obtain. Once evidence is obtained, prosecutors have to exercise fine judgment in order to determine whether prosecution is justified. A fractious working relationship between Police and lawyers could only have made the tasks for each side more fraught with difficulty.

10.329 We have concluded, however, that the essential policing work and the process of giving legal advice and making prosecuting decisions were not significantly affected by the disputes.

10.330 The Operation Rectangle Police team was staffed by experienced officers, with DI Fossey having a leading role as Deputy SIO. We have seen no evidence to indicate that the evidence-gathering role of the Police was hindered to any material extent by the bad relationship between lawyers and the Police.

[246] Day 120/155

10.331 Equally, as we discuss in more detail in Chapter 11, the Crown Advocates made conscientious decisions and gave proper advice. To the limited extent that the Attorney General was involved in decision-making, he acted with integrity. His notes of his discussions with Graham Power and Lenny Harper certainly reveal the tensions between the lawyers and the Police, but also reflect a willingness on his part and that of Graham Power to resolve difficulties if possible. We have no reason to believe that any decision made or advice given was improperly influenced in any way by the unhappy nature of the working relationship with the Police.

10.332 The arrival of David Warcup and Michael Gradwell clearly improved the working atmosphere, but we have no reason to believe that the integrity of the work of either Police or lawyers was affected by the change in Police leadership of Operation Rectangle.

The suspension of Graham Power

10.333 In November 2008, Graham Power was suspended by the then Home Affairs Minister, Andrew Lewis. The reasons given, in essence, related to alleged failings in the management of Operation Rectangle.

10.334 Operational policing decisions are not a matter for this Inquiry save to the extent that they had an effect on the Police response to allegations of the abuse of children in care. As counsel to the Inquiry submitted, opinions given after the event are of limited assistance. The central question we have to address is “What was the reason for Mr Power’s suspension?” If it was motivated by a desire to close down Operational Rectangle and promote a cover-up then it does not matter that there might incidentally have been legitimate reasons for suspending him. If on the other hand his suspension was not motivated by any such desire, it does not matter whether his suspension was in fact illegitimate (for example, due to procedural failings), and any effect his suspension had on the Operational Rectangle investigation would have to be regarded as an inevitable but legitimate consequence. The reason for our consideration of this issue is that it falls squarely within the requirement for us to investigate, under Term of Reference 9, the actions of the agencies of the government and politicians

when concerns came to light about child abuse and establish what, if any, lessons are to be learned. Term of Reference 11, which requires us to consider the actions taken by entities, including the Police, to reports of child abuse, is also relevant.

10.335 In August 2008, David Warcup asked the Metropolitan Police to carry out a review of Operation Rectangle. The purpose of the review was to assist those involved in the investigation by identifying matters that needed improvement and tasks that should be undertaken.[247]

10.336 Michael Gradwell said that both he and David Warcup were concerned that Graham Power would not engage in discussions about the issues that they were raising. Michael Gradwell wrote a report to his line manager David Warcup to record his concerns; that report was made available to the Inquiry.[248]

10.337 He set out a number of criticisms concerning the conduct of Operation Rectangle, including matters in respect of the day-to-day running of the investigation and media handling. He expressed the strong view that misrepresentations in the media must be corrected publicly, first because that was the right thing to do and secondly as a pre-emptive response to the inevitable abuse of process arguments from defendants.

10.338 Both David Warcup and Michael Gradwell were dismayed by Graham Power's disapproval of their plan to hold a press conference. Graham Power considered that the record should be put straight in a more "low-key" way.[249]

10.339 David Warcup reported his concerns to Bill Ogley, Chief Executive and also met with Assistant Home Affairs Minister, Andrew Lewis. Andrew Lewis was concerned with the impact that "*sensationalist*" reporting had had on the SOJP and on the reputation of Jersey more generally.[250]

[247] Day 120/102; WD 008713/41
[248] WD008514/20
[249] Day 120/54–58
[250] Day 120/67

10.340 David Warcup hoped that Bill Ogley and Andrew Lewis would be able to persuade Graham Power to help deal with Lenny Harper who, having left the SOJP, was still giving media briefings.[251]

10.341 Bill Ogley told the Inquiry that his major concern was that Graham Power, as CO, could stop the press conference from going ahead. He said that a plan was created to deliver the press conference without confronting Graham Power. Steps were also taken to ensure that Graham Power could be suspended on the day of the press conference "*if necessary*".[252]

10.342 Bill Ogley took advice from the Solicitor General on the disciplinary process. The advice provided by the Solicitor General, Timothy Le Cocq QC to Bill Ogley and to Frank Walker, Chief Minister, was given only in connection with the process itself and not the substance of the decision.[253]

10.343 The Minister for Home Affairs, Senator Wendy Kinnard, due to a conflict of interest, had handed responsibility for matters relating to Operation Rectangle to the Deputy Minister Andrew Lewis.

10.344 Bill Ogley told the Inquiry that David Warcup briefed him on the oral reports that he received from the Metropolitan Police reviewer. An interim report was expected, and David Warcup expected that report to be critical of Graham Power.[254]

10.345 On 18 October 2008, Senator Wendy Kinnard met her deputy Minister, Andrew Lewis, at her home. Her husband, Christopher Harris, a lawyer, was present for some of the meeting and shortly afterwards drafted a handwritten note of the main points. According to Senator Wendy Kinnard, Andrew Lewis told her of steps being taken to remove or discipline Graham Power. He told her about "*extracts*" from a Metropolitan Police report and said "*for God's sake don't tell Frank what I'm telling you".* She advised Andrew Lewis not to do anything until he had full information. She was reassured when he told her that he would stand up to any pressure to invoke suspension. Senator Wendy Kinnard had no further discussions with Andrew Lewis about the

[251] Day 120/72
[252] Day 129/62
[253] WD009129; WD009097
[254] Day 129/72

proposed suspension of Graham Power.[255] On 20 October 2008, she resigned as Minister for Home Affairs. She was succeeded by Andrew Lewis.

10.346 Andrew Lewis denied that there were any discussions about Graham Power's suspension and asserted that Christopher Harris's note was fabricated. He claimed to have known nothing at all about the proposed suspension until 11 November 2008, despite the fact that, as Home Affairs Minister, he would have been the only person with the power to suspend the CO.[256] Both Senator Wendy Kinnard and Christopher Harris gave evidence to the Inquiry, attesting to the accuracy of the note. We accept the account that they gave to us about their meeting with Andrew Lewis.

10.347 Dr Brian Napier QC, an expert in employment law, subsequently investigated Graham Power's suspension. Andrew Lewis told Dr Brian Napier that, between 22 and 28 October, he had discussed with Mr Crich (Director of HR) and Bill Ogley the possibility of Graham Power being suspended. Andrew Lewis said in evidence to the Inquiry that he may have got "*muddled*" when talking to Dr Brian Napier. However, we find that Andrew Lewis was not muddled. His account to Dr Brian Napier provides confirmation of the accuracy of the evidence of Senator Wendy Kinnard and Christopher Harris about their meeting with Andrew Lewis; he clearly knew well before 11 November 2008 of the plan to suspend Graham Power.

10.348 On 6 November 2008, Timothy Le Cocq QC, Solicitor General, advised that the Ministers did have the power to suspend the CO while that Officer was absent from the island. He added:

> *"Whether it would be wise to do so is, of course, a different question, the answer to which will depend on the content of the [Metropolitan Police] report."*[257]

10.349 The Solicitor General also advised that Graham Power should be shown that report and invited to comment on the basis that the Minister regarded it as serious and was considering suspension.

[255] Day 135/166–180
[256] Day 136/27–42
[257] Day 132/95

10.350 The Metropolitan Police had not delivered their report by this point; they were waiting to interview Lenny Harper. David Warcup asked for an interim report which he received on 10 November 2008.[258]

10.351 On 11 November 2008, the Solicitor General advised on the content of a letter of suspension and noted:

> *"I reiterate my advice that if this action is being considered in advance of the full report being available from the Metropolitan Police, there must be sufficient objective evidence available to justify what is proposed. I would urge that particular caution be exercised to check there are no provisos or caveats to any of the conclusions reached upon which reliance is to be placed and that the reasons for action are robust."*[259]

10.352 David Warcup did not provide a copy of the report to Bill Ogley but set out in a letter his criticisms of the way in which Operation Rectangle had been conducted.[260]

10.353 In his letter dated 10 November 2008, David Warcup made extensive criticisms of the management of Operation Rectangle under Lenny Harper. In the concluding part of the letter he wrote:

> *"the interim findings of the review by the Metropolitan Police fully support my previous comments and the opinions which I have expressed herein".*

10.354 David Warcup was asked, in his oral evidence, about the accuracy of that last sentence and accepted that it gave a misleading impression as his comments and opinions in the letter went "*far beyond those expressed in the interim report*". However, he said that he made "*a very clear distinction about what my views are and what the Met findings are* ".[261]

10.355 David Warcup told the Inquiry that he had not known in advance that Graham Power was to be suspended.[262]

[258] Day 120/107
[259] WD009097
[260] Day 120/115
[261] Day 120/131
[262] Day 120/143

10.356 Frank Walker (Chief Minister) said that David Warcup's letter was so damning in itself that it would have led to the suspension of Graham Power, with or without reference to the Metropolitan Police review.[263]

10.357 In an email dated 11 November 2008, the Attorney General, advising on the content of a proposed press release, wrote:

> *"If you get to the stage of suspending Graham Power then of course **some** statement will be necessary, but surely you will need to have the full Met review in your hands for that purpose and allow a little time for it to be assimilated."*[264]

10.358 Frank Walker said that William Bailhache QC's comment was based on the incorrect premise that the Metropolitan Police report was the reason for suspension; it was, he said, all the other evidence in David Warcup's letter that was the reason for the suspension.[265]

10.359 According to Andrew Lewis, he first knew on 11 November 2008 of any possibility of Graham Power's suspension when Bill Ogley told him that concerns had been expressed by David Warcup about Operation Rectangle. Bill Ogley wanted to discuss "*a way forward*", and Andrew Lewis recognised at the time that suspension was a very real possibility.[266]

10.360 Andrew Lewis admitted to us that he knew on 11 November 2008 that the Metropolitan Police had said that the review was not to be used for disciplinary purposes. He saw nothing wrong, however, with using extracts or observations from it when deciding whether to suspend Graham Power.[267]

10.361 He said that he could not recall whether he had been aware of the Solicitor General's advice that he should ensure, before relying on the report, that there were no caveats in it.[268]

10.362 On 11 November 2008, following the briefing to politicians about the press conference, a further meeting was held. It was attended by Frank Walker,

[263] Day 124/148
[264] WD008945; in oral evidence William Bailhache QC emphasised that it was the SG, and not he, who had been asked to advise on the procedure for suspension
[265] Day 124/54–55
[266] Day 136/45
[267] Day 136/53
[268] Day 136/59

Bill Ogley, Andrew Lewis and the Attorney General.[269] David Warcup did not attend the meeting.

10.363 The Attorney General, William Bailhache QC, told the Inquiry that he understood at that meeting that the decision to suspend Graham Power had already been taken. Bill Ogley believed that the meeting was called for the purpose of deciding whether to proceed with the suspension and, if so, how to do it.[270]

10.364 Bill Ogley said that it was decided that Graham Power should be given time to consider the information in the suspension letter and then have an opportunity to respond before the Minister made a final decision.[271]

10.365 Graham Power was told, on the evening of 11 November 2008, that Bill Ogley and Andrew Lewis wanted to meet him the following morning to discuss "*some concerns that had been raised about Operation Rectangle with reference to the review that had just been completed".* He was not told that suspension was being considered. Andrew Lewis was asked in evidence whether it would have been fair to give Graham Power the chance to consider matters and to consult a lawyer or bring a colleague. He replied "*he had all that opportunity afterwards*" and stated that this was not dismissal but suspension.[272]

10.366 Graham Power was suspended from his post on 12 November 2008, the same day as the press conference. Graham Power said in evidence that there was one crucial inaccuracy in the record of his meeting with Bill Ogley and Andrew Lewis. The note of that meeting stated that he had been invited to take an hour "*to consider matters*". He said that he was given an hour "*to consider his position*" and that there was no doubt that he was being invited to resign as an alternative to suspension.[273]

10.367 On 10 December 2008, Andrew Lewis took part in an "in camera" debate in the States concerning Graham Power's suspension. In that debate he said

[269] Day 129/83
[270] Day 129/82
[271] Day 129/84
[272] Day 136/65
[273] Day 107/177; WD007216

that an investigation had been carried out by the Metropolitan Police and that he was presented with a preliminary report:

> *"When I saw the preliminary report I was astounded. So much so that my actions, I believe, are fully justified. If the preliminary report is that damning, Lord knows what the main report will reveal."*

10.368 In answer to the question posed during the debate – "*Will the report be published when it is completed?"* – Andrew Lewis replied:

> *"No, it will not, because the report of the Metropolitan Police contains Crown evidence that will be used in the prosecutions that are currently underway and potential prosecutions that may come from this investigation."*

10.369 At this time, Andrew Lewis had not seen the Metropolitan Police report. In evidence to this Inquiry Andrew Lewis said that he had made an error during the debate in referring to the Metropolitan Police report when he meant to refer to David Warcup's letter. He did not accept that anyone had been misled and said that those present on the day understood that he had been referring to David Warcup's report. He was given the opportunity to identify passages in the Hansard report of proceedings that would lead anyone present (or reading the debate) to understand that he was referring to David Warcup's letter. He was unable to do so; the report in Hansard contains no references whatsoever to David Warcup's letter.[274]

Findings: the suspension of Graham Power

10.370 Dr Brian Napier QC presented a report to the States on 15 November 2010. In it he concluded that the decision to suspend Graham Power was procedurally flawed. Frank Walker told the Inquiry that he accepted Dr Brian Napier QC's view; the circumstances for immediate suspension did not exist and no consideration was given to alternatives such as special leave.[275] However, Frank Walker maintained that he had acted on legal advice that immediate suspension was necessary pending investigation into Graham Power's alleged failings. He said:

[274] Day 138/56ff Deputy Mike Higgins was instrumental in obtaining States permission for the Inquiry to see the Hansard report of those proceedings
[275] Day 124/61

> *"Was there a conspiracy, as has been alleged by previous witnesses, not least Mr Power himself, was there a conspiracy to remove him from office and the answer is categorically 'No'. He was suspended because he totally failed to take any meaningful control of Operation Rectangle and his investigating officer."*[276]

10.371 Dr Brian Napier QC found no evidence of a conspiracy to oust Graham Power for some improper purpose.

10.372 However, Dr Brian Napier QC did not have the advantage that we have had of calling a substantial number of witnesses to give evidence on oath; nor did he have all of the material that we have received. He did not know (and could not know) that Andrew Lewis would give a different account to us from the one that he gave to Dr Brian Napier QC. In these circumstances, while we do not question Dr Brian Napier QC's findings on procedural irregularities, we do not believe that we should place great weight on his findings concerning the existence or absence of a conspiracy.

10.373 We do have to record our disquiet at the manner in which the suspension was handled and in respect of some of the evidence given to us about it. We refer, in particular, to the following issues:

- Graham Power was suspended with no notice in respect of alleged past failings, when there was no suggestion that those past failings could have an effect on his ability in future to carry out his duties;
- Those responsible for his suspension did not heed the advice of the Solicitor General or Attorney General about the risks of reliance on the Metropolitan Police interim report, the need to show any report to Graham Power and permit him to comment on it, or the wisdom of awaiting the full Metropolitan Police report before taking action;
- David Warcup exaggerated to Bill Ogley the extent to which his own concerns were supported by the Metropolitan Police interim report;
- Andrew Lewis used the interim report for disciplinary purposes, knowing that this was an impermissible use;
- William Bailhache QC, as Attorney General, understood that the decision had already been made by the evening of 11 November 2008 that Graham

[276] Day 124/65

Power was to be suspended. His evidence to us on this point was at odds with the evidence of Bill Ogley. We prefer the evidence of William Bailhache QC;

- It is clear to us that, when Graham Power attended the meeting on 12 November 2008, his suspension was inevitable. We accept Graham Power's evidence that he was given time "to consider his position" – in other words, to resign as an alternative to suspension;
- Andrew Lewis lied to the States Assembly about the Metropolitan Police report, pretending that he had had sight of it when he had not;
- Andrew Lewis told Dr Brian Napier QC that he had discussed the suspension of Graham Power in October 2008, while telling us that he knew nothing about it until 11 November 2008;
- Andrew Lewis denied that he had discussed with Wendy Kinnard and Christopher Harris the possibility that Graham Power would be suspended. We do not accept his evidence in this respect.

10.374 We can readily see why these acts have given rise to public suspicion that all or some of those involved were acting improperly and that they were motivated by a wish to discredit or close down investigations into child abuse. However, we have to examine with care the evidence that we have, and to be aware both of its limitations, and of the limited remit that we have within our Terms of Reference.

10.375 We recognise that there were, at the time of Graham Power's suspension, genuine reasons for concern about some aspects of the past conduct of Operation Rectangle (and, in particular, the media handling) and that there may well have been reasons to investigate whether (a) there were failings in the conduct of the operation; and (b) if there were, the extent to which Graham Power was responsible for them.

10.376 We cannot be sure why Frank Walker, Bill Ogley and Andrew Lewis acted as they did, or why Andrew Lewis lied both to the States and to us.

10.377 Frank Walker described Andrew Lewis as an inexperienced politician, and even appointed a more senior politician to mentor him in his Home Affairs

role.[277] While Frank Walker told us that, nevertheless, he did not think that Andrew Lewis would have been influenced by his view as Chief Minister, we believe that such influence was not only inevitable but would have been recognised by all involved, including Frank Walker and Bill Ogley.

10.378 There is no evidence that Andrew Lewis or anyone else was involved in an attempt to derail Operation Rectangle or otherwise cover up child abuse by participating in the orchestrated removal of Graham Power. It was clear that Operation Rectangle was going to continue with or without Graham Power's presence; he had never, in any event, had a significant operational role in the investigation and, following the arrival of David Warcup, had been content to leave the running of the investigation to David Warcup and Michael Gradwell. Neither of them came from Jersey, and we have no reason to believe that they would have taken the opportunity of Graham Power's suspension to close down the investigation or to take any other steps that they would not have taken had he remained in post. Operation Rectangle did not conclude until DI Alison Fossey and her colleagues were confident they had accounted for every child who had been resident at HDLG.

10.379 Our interest in Operation Rectangle in this context is in whether any decisions made by Police officers, lawyers, civil servants or politicians were motivated by a desire to cover up child abuse, or to interfere in any other way with a Police investigation into, or prosecution of, alleged child abusers. Nothing that we have seen suggests that the suspension of Graham Power was motivated by any wish to interfere with Operation Rectangle or to cover up abuse. Since our remit is limited, it would be wrong for us to speculate as to the reasons for which those involved in Graham Power's suspension acted as they did.

The issue of corruption

10.380 Both Lenny Harper and Graham Power believed that corruption was endemic in policing in Jersey. That belief, whether right or wrong, informed their thinking and their approach to Operation Rectangle. We find that their

[277] Day 124/50

belief in the existence of local corruption made them wary when dealing with the politicians, lawyers and other Police officers with whom they were working. Graham Power, in evidence to us and during the time of Operation Rectangle, referred repeatedly of the lack of trust held by the public in establishment figures, and wrote of the perception that he, the Attorney General and the Chief Executive were all members of the same "senior club".[278] We have seen no evidence of corruption that in fact affected Operation Rectangle or the investigation into child abuse.

10.381 Michael Gradwell told the Inquiry that in all of his discussions with the Law Officers and legal teams about proposed prosecutions, the lawyers would form a view of the case but were always open to discussion. He had no concern that they were acting anything other than professionally.[279]

10.382 Neither Lenny Harper nor Graham Power has suggested that the LOD or the Attorney General did anything in relation to the investigation that suggested an intent to cover up child abuse.

10.383 Lenny Harper told the Inquiry that he found there to be many instances of Police corruption within the SOJP. Graham Power said that at the time of Lenny Harper's appointment the SOJP had a history of inappropriate, illegal and unprofessional behaviour by some officers and that the leaking of information to criminals was a problem.[280]

10.384 The LOD submits that both officers gave evidence of struggles they faced trying to tackle the issue of corruption. However neither can point to any specific evidence in relation to Operation Rectangle. Furthermore neither did anything to investigate their concerns.

10.385 The Inquiry received some evidence about allegedly corrupt activities prior to Operation Rectangle.[281] These allegations are however unrelated to our Terms of Reference and we therefore make no findings in that regard.

[278] WD007070, p.331
[279] Day 111/108
[280] Day 121/16; Day 106/146
[281] Day 121/28

10.386 Whether there was at any time a problem with Police corruption is not within our Terms of Reference save insofar as it has any relevance to the investigation of allegations of abuse of children in care. Counsel to the Inquiry submitted that what is crucial is not whether there was in fact endemic corruption but whether Graham Power and Lenny Harper believed that there was. The Panel considers that Lenny Harper and Graham Power did hold that belief, and that it informed their decision making during Operation Rectangle. Their belief contributed to the difficulties in the working relationships between the SOJP, prosecuting lawyers and politicians.

CHAPTER 11

Decisions on Prosecutions

11.1 In order to assist us to determine, as required by Term of Reference 13:

i. Whether those responsible for deciding on which cases to prosecute took a professional approach; and

ii. Whether the process was free from political or other interference at any level;

we instructed independent leading counsel in London. Nicholas Griffin QC was asked to, and did, examine eight sample prosecution files and to give an opinion[1] on the approach to and decisions made in each case by those involved in case preparation and decision making.

11.2 It does not, in fact, matter whether Nicholas Griffin QC would have come to the same prosecuting decision in any particular case. We recognise that, in fields such as this, where professional judgement has to be exercised, two competent individuals may reasonably reach different views. What Nicholas Griffin QC was reviewing was the professional competence of those involved in the decision-making process.

11.3 Most, but not all, of the decisions reviewed were made during the course of Operation Rectangle and are a representative sample of the working practice of the prosecuting authority. The eight prosecution files were:

- WN279 and WN281
- Jane and Alan Maguire
- WN7
- WN491
- WN246
- WN335
- Les Hughes
- Anthony Watton.

[1] WD008989

11.4 In summary, Nicholas Griffin QC concluded that the decisions were appropriately and properly taken. Nicholas Griffin QC agreed, when asked in evidence, that, even if he would have reached a different decision in any particular case, it did not follow that the original decision was not made in a professional manner.[2] The question is whether the decision made in each case was made professionally, without undue influence, and with a correct application of the law to the facts. It is our role to take into account the evidence of Nicholas Griffin QC, and all other relevant evidence, and come to our own conclusion on these issues.

The prosecution system

11.5 The Attorney General (AG) is the principal legal adviser to the States of Jersey, as well as being the head of the prosecution service. This dual role (as seen in the other Crown Dependencies) has been the subject of some criticism.

11.6 The nature of the role was reviewed by Lord Carswell, and his conclusions were set out in his independent review in 2010. He concluded, among other things, that Jersey had been well served by a succession of distinguished Crown Officers and that the Law Officers' Department (LOD) should continue to be responsible for prosecutions.

11.7 The current Bailiff of Jersey, William Bailhache QC (who was AG from February 2000 until November 2009), was aware of the challenges posed by his multi-faceted role during Operation Rectangle:

> *"I was always conscious of potential conflicts and if a conflict of interest did arise, this was easily solved by delegating responsibility. If necessary, advocates from the private sector would be instructed to act. As Attorney General, I could not distance myself from my duty to take prosecution decisions but I could delegate other areas of work."*[3]

11.8 All prosecutions in Jersey are brought in the name of the AG. A Crown Advocate is a Jersey qualified advocate appointed by the AG to act on his behalf as a prosecutor.

[2] Day 133/9, 13–21
[3] WS000701/45–6

11.9 John Edmonds joined the LOD in June 2008, as Head of the Serious Crime Section. He was an experienced prosecutor who had practised until that time exclusively in England. He had no connections at all to Jersey. LOD was restructured in October 2009 and John Edmonds became Director of the Criminal Division – a post he still held when he gave evidence to the Inquiry.[4]

11.10 The Inquiry's focus in relation to Term of Reference 13 was whether the decision-making process involved any impropriety or was affected by any political or other interference. We were assisted by John Edmonds' evidence in that regard:[5]

> *"Q. Throughout the time that you were involved in decision-making in Operation Rectangle, whether you were making the decisions yourself or considering the decisions of others, did you ever feel uncomfortable professionally with what was being done?*
>
> *No, never.*
>
> *Q. What would you have done if you had?*
>
> *A. Well, as you have indicated, I had no ties with Jersey. My family, children, grandchild, mother and my wife's father are all in the UK; we would have gone back.*
>
> *…*
>
> *Q. Were you aware that there were politicians who were very concerned that the publicity associated with Rectangle was damaging the Island's reputation both as a financial centre and as a tourist centre?*
>
> *A. Yes, I was aware that that type of view was being expressed, yes.*
>
> *Q. Did that have any influence on decision-making within the Law Officers' Department?*
>
> *A. Absolutely not.*
>
> *Q. Was it ever discussed within the Law Officers' Department?*
>
> *A. I don't remember that topic being discussed, but there was never any discussion about how this is going to impact on Jersey other than how will it impact on Jersey if we don't do this right.*
>
> *Q. What was the answer to that question?*

[4] Day 126/5–10

[5] Day 126/57–59

> *A. That we had to do the right thing. We had to ensure that allegations were rigorously investigated and that we were making decisions that we hoped would withstand objective scrutiny."*[6]

John Edmonds also summarised the position as follows:[7]

> *"The role of the Attorney General requires him to provide legal advice to the States of Jersey … In normal circumstances I do not believe that there is a conflict with the Attorney General's various roles. Shortly after I arrived in Jersey in 2008 the Attorney General identified a potential conflict arising from his department providing legal advice to the States of Jersey in relation to the civil claims made by historic abuse survivors. The issue and potential conflict was that the Attorney General might be required to make a decision about whether to prosecute an individual in respect of whom a civil claim was to be made. To avoid such perceived conflict, the Attorney General indicated to the States that he would not provide advice to the States in relation to any redress scheme. Consequently the work in relation to this advice went to an external Jersey-based firm. In my experience any such potential conflicts are routinely identified and managed before any problems arise."*

11.11 During the course of his evidence, John Edmonds was asked whether it was possible that the AG might not have wanted to prosecute child abuse cases in order to protect the wider reputation of Jersey. He replied:

> *"It isn't what happened. I'm entirely clear that all Attorney Generals for whom I worked take a very serious view of serious criminal offending, including child abuse, and would want to prosecute. It seems to me to be clear that Jersey was going to be judged not so much by what had happened in the past, because one can't change the past, the way Jersey is going to be judged, or was going to be judged, was how it dealt with it. To cover it up, to try and pretend it hadn't happened wasn't going to make it go away because as a tactic that might work for a couple of years, but it will come back again, so what was important was how we dealt with it … there and then."*

11.12 Prosecution decisions in Jersey are made in accordance with the same two stage test that has for many years been applied in England and Wales. This was set out in writing when the UK Crown Prosecution Service (CPS) first came into being in 1986. The Code for Crown Prosecutors requires an objective assessment of the evidence, addressing the question: is a conviction more likely than not? If the evidence passes that test, there is then a subjective assessment of the public interest, namely: is it in the public

[6] Day 126/57–59
[7] WS000698/7

interest that this offender/offence be prosecuted? This test was set out for Jersey lawyers in the Code for Prosecutors, issued in 2000 by Sir Michael Birt QC, AG from 1994 to 2000.

11.13 Nicholas Griffin QC noted:[8]

> *"The Code on the Decision to Prosecute in Jersey is dated January 2000. I have not been provided with information to show what was applied before this date. However, it is clear from the documents I have seen that the dual evidential and public interest test was being used by the Law Officers' Department before 2000."*

The evidential test

11.14 William Bailhache QC was asked about various factors that a prosecutor would consider when determining whether the evidential test was met. He said that the reliability of a witness was a factor to be considered. If there were mental health issues or alcohol or drug problems the prosecutor would be sensitive to the possibility that those problems had been caused by abuse. Nevertheless "*you have to persuade a jury to convict despite (those problems) rather than because of them".*[9] He also said that the presence of corroborative evidence would mean that credibility issues were of less significance.[10]

11.15 Sir Michael Birt QC said:

> *"the credibility of any witness is a factor and various matters can go into credibility, for example if somebody has a criminal record as long as your arm and is guilty of lots of offences of dishonesty that may affect their credibility in the case so it's something you weigh in the balance but you certainly don't say "we're not going to prosecute because our witness has behavioural or psychological problems".*[11]

The public interest test

11.16 John Edmonds said[12] that the Centeniers had sometimes found it difficult, when applying the two-stage test on whether to prosecute, to distinguish between private interest and public interest. By way of example, some Centeniers were not, he said, prosecuting in domestic violence cases

[8] WD008989/17
[9] Day 128/6–10
[10] Day 128/15
[11] Day 131/33
[12] Day 126/19–21

because a conviction would cause the man to lose his job. In the view of the LOD that was a matter of private, not public interest. He said that the Force Legal Advisers all provided regular training for Centeniers.

11.17 William Bailhache QC was asked about the public interest test in the context of Operation Rectangle. He said:

> *" … One of the major public interest factors in favour of prosecution, where the evidential test was passed in Rectangle, was the need to demonstrate that the justice system in Jersey took seriously the complaints which were made and therefore my own approach was that we would prosecute, if the evidential test was passed, unless there were really important public interest reasons not to do so".*[13]

11.18 DI Alison Fossey, in a report drafted in 2010, said that in all cases in which the Operation Rectangle sub-group decided to take no further action, the decision was made on the basis that the case failed the evidential test. She said that no case was halted on public interest grounds.

11.19 Nicholas Griffin QC identified three cases in which he thought that the public interest test was a factor in the decision not to prosecute. The first was a case in which a member of staff at HDLG, WN491, was accused of having flicked boys with wet towels in the shower. The second involved a boy having chocolate mousse poured over his head by a member of staff (WN246), and the third was the Les Hughes case. He therefore believed DI Alison Fossey's assertion to be incorrect.[14] He noted that, in an Advice that dealt with a number of allegations including the chocolate mousse incident, Crown Advocate Baker said that the evidential test was not met in any of the cases, but went on to consider the public interest test in the chocolate mousse case. Nicholas Griffin QC said that the basis on which Crown Advocate Baker reached his view was therefore not clear in that case; however, *"if someone tells me in fact it was on the basis of the evidential test, then that's fine".*[15]

11.20 William Bailhache QC's recollection was that decisions not to prosecute were in every case made on evidential, and not public interest, grounds.[16] He

[13] Day 128/16–18
[14] Day 133/40–1; WD008989/14
[15] Day 133/41
[16] Day 128/65–6

added that, in some cases, such as that of WN491 (see below), the public interest test may have been relevant to the evidential test. Those circumstances arose, by way of example, when it was likely that a jury would think the assault, even if proved, too trivial and/or too old to justify conviction. In such a situation, the basic facts would pass the evidential test, since the prosecution could prove facts amounting to an assault; however, the essential evidential test – whether the prosecutor thinks it more likely than not that a jury would convict – would not be passed.[17] He gave similar evidence in respect of the chocolate mousse incident.

11.21 In his oral evidence, Nicholas Griffin QC gave the following response to William Bailhache QC's evidence on this issue:

> *" … Where he is talking about considering whether something actually is a criminal offence then that clearly is an application of the evidential test and so there's no difficulty about that. Where he's talking about proportionality and that type of thing, that seems to me to be consideration of a public interest type of factor: whether the kind of sentence that might follow would be minimal, that type of thing. So those would be the first two observations that I have. I think one of the issues is the extent to which it is appropriate when you're conducting the evidential test to take into account what view a jury might take of particular offences that have been charged and it seems to me one has to be careful when one gets to that kind of stage, and there is a case that is referred to by Crown Advocate Baker in one of his advices, I think it's in 491's case, which sets things out I think quite helpfully, and Mr Baker refers to it, but it's the case of R (on the application of B) against the DPP, it is a case from 2009, and what Lord Justice Toulson does in that case is to consider an appropriate approach for a prosecutor when deciding whether the evidential test is passed and the type of approach that he thinks is less appropriate and he favours a merits based approach and this is what he says:*
>
> > *'A prosecutor should imagine himself to be the fact-finder and ask himself whether, on balance, the evidence was sufficient to merit a conviction, taking into account what he knew about the defence case.'*
>
> *Now, that seems to me to mirror very well what you see for the evidential test in the Attorney General's Code. He then goes on to reject a predictive approach and that is based on past experience of similar cases, and it seems to me where you have a prosecutor saying 'In my experience no jury is going to convict for this type of thing', that's the predictive approach that one really shouldn't follow and it seems to*

[17] Day 128/69–70, 73

> *me that the Attorney General's Code and the equivalent CPS Code in England and Wales is easy to understand when one applies first the evidential test and only gets to the public interest test once one has decided the evidential test is passed. It becomes much more confusing where you are sort of trying to consider the two of them together and I don't think that's appropriate.*
>
> *… May I go on to say this though: even if I'm wrong and even if there is a way in which that type of public interest factor can be considered at the same time as the evidential test, I don't think that that applies in the cases that I have looked at here, because what Lord Justice Toulson has said is that there may be cases where there is good evidence and strictly speaking the evidential test is passed, but that a jury won't convict for example on moral grounds. I don't think that's the type of case that we are dealing with here so – and we may come on to the towel flicking allegations – I don't agree that these are minor allegations of horseplay that no jury would convict on, so on the basis of the facts in this case I also disagree."*[18]

11.22 In his oral evidence, William Bailhache QC was referred to Stephen Baker's observation in his Advice on the chocolate mousse incident:

> *"While this incident would of course be humiliating for a child and is technically an assault, I have no hesitation in saying that in my view it would not be in the public interest to prosecute for this matter. Indeed it would expose the prosecution to ridicule, particularly in the context of a child abuse inquiry into serious physical and sexual abuse."*[19]

11.23 William Bailhache QC said:

> *"I think any prosecutor would not want to charge if he thought the prosecution would look ridiculous, I'm sure that's true."*[20]

11.24 Referring specifically to the chocolate mousse incident, Nicholas Griffin QC said:

> *"I think it causes great difficulties if you are trying to do both [the evidential test and the public interest test] at the same time. In the chocolate mousse case, which we may come on to, it seemed to me a reasonable conclusion to decide that the evidential test hadn't been met and he talks about the previous conviction of the complainant in that case, which may -- not definitely, but may be a factor that would be conclusive, so that would be an evidential reason not to prosecute.*
>
> *The public interest reason not to prosecute would be that this was a very minor matter, years before, and would lead to a very minor,*

[18] Day 133/27–9
[19] WD008989/166
[20] Day 128/133

> *nominal sentence and that seems to me, if you have decided that there is the evidence, would be the public interest reason not to prosecute, but you would come to that after you had decided whether there was sufficient evidence.*
>
> *There was one other point that was raised in the quote that you have just read out and that is the fact that relatively minor offences might be disclosed in the context of a major investigation into very serious sexual abuse and whether that in itself is something that it is appropriate to take into account in deciding whether to charge and I think I have seen that in more than one of the cases that I have looked at. It seems to me that the fact that criminal offences are disclosed in the context of an inquiry looking into something else is not of itself a reason not to pursue them. There may be other reasons not to pursue them, but the fact that a common assault comes out of a murder investigation isn't of itself a reason not to pursue the common assault and I think the Attorney General, or one of them, actually makes a similar point in relation to the towel flicking allegations."*[21]

11.25 In his AG's Review of 2008, William Bailhache QC addressed one aspect of the public interest question in the following way:

> *"Before leaving the historic child abuse investigation, I would like to add this. While there have been some complaints of serious offences having been committed, the investigation has covered an enormous amount of ground, and perhaps has gone rather wider than was first intended when it was originally conceived. Certainly the completed investigation files which lawyers have had to consider in the context of deciding whether or not to prosecute have quite frequently revealed complaints of alleged assault which would have been at the lowest end of the scale even if the case files had been produced a week after the incident in question. Complaints of slaps to the head, being flicked with a wet towel, or being made to take cold showers and the like are so far divorced from the public's perception of the nature of this enquiry that it is right to say that at least in relation to a significant number of the case files received, the complaints, even if capable of being proved to the criminal standard, which in most cases has not been thought possible, are not matters which are suitable for the criminal courts even today, let alone 30 years after the event."*[22]

11.26 Nicholas Griffin QC, in his oral evidence to the Inquiry, summarised his view on the application, during Operation Rectangle, of the evidential and public interest tests:

> *"other than the cases where I have pointed out that I think there may be a conflation or an inappropriate application of the test, it seems to*

[21] Day 133/35–36
[22] WD009064/133

me they were correctly applied and I should add this: some of these cases were very difficult from a lawyer's point of view and some of the advices I have seen have been impressive in certain respects and may I give an example? Where Crown Advocate Baker is talking about whether the various different complainants' evidence in the towel flicking allegation[23] *are mutually corroborative I think he does that in a very – that's a difficult concept applied in the context of a difficult case – and he has done that I think very well. So there are examples of very good application of expert legal opinion to the cases and I think there are some that are less strong".*[24]

The charging decision

11.27 The decision on whether to charge a suspect usually lies with the Centenier, although the AG may exercise his power to commence proceedings in the Royal Court by "Direct Indictment".[25]

11.28 John Edmonds did not believe that the Centeniers' lack of legal training had ever caused a problem in decision-making: "*The Centeniers know that they can always go to a legal adviser (within the Law Officers' Department) if they are unsure."*[26]

11.29 He said that the AG had issued guidance in respect of specific offences to assist Centeniers in their decision making. In respect of domestic abuse, which includes the physical and sexual abuse of children, a zero tolerance approach was advocated. If the evidential test were met, prosecution would always be in the public interest unless there were exceptional circumstances.

In Operation Rectangle, charges were brought by Centeniers only after the cases had been scrutinised by lawyers. Certain cases earlier than Operation Rectangle were also reviewed by lawyers before a decision was made whether or not to advise a Centenier to charge. We have not seen evidence of any Centeniers, without the input of lawyers, refusing to charge alleged perpetrators of child abuse.

[23] Please see the discussion, at paragraph 11.105 below, about the case of WN491

[24] Day 133/36–37

[25] WS000698/4/13

[26] Day 126/13

The procedure in Operation Rectangle

11.30 William Bailhache QC told the Inquiry that, as AG, he was consulted by Lenny Harper on 7 January 2008 and given details of the number of victims and suspects who had been identified.

11.31 William Bailhache QC realised that the LOD would need to secure external Crown Advocates as independent prosecutors to work on the Rectangle cases, partly because of the scale of the investigation, partly because of the expertise of these Crown Advocates', and partly to avoid conflicts arising, if an external Crown Advocate were instructed to prosecute in one case and defend in another. Crown Advocate Baker of Baker Platt was therefore instructed to prosecute the Rectangle cases.

11.32 It was agreed that if Crown Advocate Baker (or one of his team) advised that there should be a prosecution, then a Centenier would charge a suspect. If the advice was that the suspect should not be charged, the file had to be forwarded to the LOD for review by the AG.

John Edmonds said that there was a good working relationship between Baker Platt and the LOD, with meetings taking place most weeks.[27]

11.33 William Bailhache QC said that the sensitive cases involving allegations against States employees would be referred to him. In any case where the Crown Advocates advised against charging, they had to draft an Advice Note so that the case could be considered by the AG, John Edmonds and sometimes external counsel. When the Operation Rectangle Gold Group was established, following the arrival of David Warcup in August 2008, a sub-panel of that group was created to consider whether to prosecute in each case. Members of the sub-group included John Edmonds, SOJP representatives, independent Crown Advocate Stephen Baker and UK barrister Simon Thomas. The sub-group applied a matrix system in order to identify and prioritise the strongest cases.[28]

[27] Day 126/34–35
[28] Day 128

11.34 Nicholas Griffin QC commented that the sub-panel was a “high-level" one in terms of its members and that the prioritisation system was, in his view, a proper one.[29]

11.35 In March 2009, the LOD suggested to DSupt Michael Gradwell that the SOJP alone should make decisions in cases that did not meet the threshold test for prosecution so that the expense of advices from Baker Platt could be avoided. DSupt Michael Gradwell replied:

> *“I would prefer to persist with the current prosecution team approach because of where we are now and how we have got into this position. Due to the history I think it is important that legal advice is sought in all these cases, despite there being an obviousness to some of the decisions.”*[30]

DSupt Michael Gradwell’s view prevailed.

11.36 One of the questions that we had to address was whether the retirement of Lenny Harper and the arrival of David Warcup and Michael Gradwell led to a change in the police approach and, specifically, whether David Warcup and Michael Gradwell (or anyone else) then acted with a view to closing down Operation Rectangle. The sub-group considered cases in which the SOJP had not yet done much work, in order to decide whether prosecution should be pursued. John Edmonds said that while the police had a large number of issues with which to deal he had no impression that they were trying to close things down:

> *“It was a question of trying to deal with things appropriately”.*[31]

He did not recall any instance of a significant dispute between the SOJP representative and the lawyers as to the future of any investigation.

We consider that the approach of the SOJP to Rectangle prosecutions remained essentially the same throughout the history of the operation; the police wished to prosecute alleged offenders where there was evidence to justify prosecution. There was no attempt, following the arrival of David Warcup and Michael Gradwell, improperly to close or reduce the scope of the

[29] Day 133/17–18
[30] WD00900/15
[31] Day 126/68

investigation. Inevitably, the operation had to come to an end at some point, and they had to manage that process; however, we have no doubt that, throughout the length of the operation, all policing and prosecuting decisions were made conscientiously and properly. We note that DSupt Michael Gradwell insisted on having legal advice, even when the decision not to prosecute seemed obvious.

Specific cases considered by Nicholas Griffin QC

WN279 and WN281

11.37 This case involved allegations of cruelty and physical assault on the part of WN279 and WN281, Houseparents at a FGH. The allegations related to events in the period from 1967 to 1977, when WN279 and WN281 were in their late 20s to late 30s. Other aspects of the case are considered above.

11.38 The complainants were three foster children who lived at the Home. In summary, the allegations were that there was a vicious regime of discipline and brutality at the FGH, with frequent beatings by both WN279 and WN281. There were numerous allegations of the foster children being lined up for physical punishment, with either WN279 or WN281 smacking the children, hitting them with a plastic cricket bat, or using a belt. Other complaints included children being hit round the head and beatings with a hairbrush.

11.39 The allegations were denied and contradicted by other children resident in the Home.

11.40 A dispute arose in June 2008 between the SOJP and the LOD as to whether WN279 and WN281 should be charged. The police wished to charge WN279 and WN281, and Lenny Harper expected that they would do so, having understood that the lawyers advised that charges should be brought.[32]

11.41 Following the arrest of WN279 and WN281, Simon Thomas advised that he wished to wait until the suspects had been interviewed, and then consider charges in the light of anything said in interview. His advice in that regard was correct.

[32] Day 122/48–85

11.42 Andrew Smith, a police officer who served with Operation Rectangle, gave a statement to the Inquiry but was not called to give oral evidence. He said that it was never the practice for lawyers to agree to charge a suspect before the person had been interviewed, and that it was his "*vivid recollection"* that Simon Thomas did not commit to charging WN279 and WN281 before their arrest.[33] The dispute became public, with both the SOJP and the AG issuing press statements to explain their respective positions. The parties involved rightly accept that this disagreement was damaging to the relationship between police and prosecutors.[34] Crown Advocate Baker was right to be concerned that a public dispute was possibly fatal to any prosecution.

11.43 On 14 August 2008, the AG, John Edmonds, Crown Advocate Baker and Simon Thomas attended a meeting with DS Alison Fossey and other police officers to discuss the case. They agreed to postpone a decision on charging pending the decision by one final witness as to whether she was prepared to make a statement.[35]

11.44 Ultimately, the decision was taken not to charge WN279 and WN281. John Edmonds told the Inquiry that he was clear that the decision was made properly and appropriately. Even with hindsight, he had no concerns about the way in which the decision was made.[36] In his witness statement he said:

> *"Unfortunately, the States of Jersey Police press statement made by Lenny Harper in June 2008 had made the environment much more challenging for those investigating and advising on the case involving WN279 and WN281. A lot of our time was spent fielding interest from various media outlets, both in the UK and Jersey. Consequently, time that could have been devoted to the decision-making process was given to media management. While I am confident that we made the right decisions, the time spent in responding to media enquiries slowed down the process at times."*[37]

11.45 In his oral evidence he said that media distractions did not influence the decision making.[38] We accept his evidence in that regard.

[33] WS000712/2–5
[34] WD009000/347
[35] WD009000/358
[36] Day 126/112
[37] WS000698/39/117
[38] Day 126/114

11.46 Nicholas Griffin QC reached the following conclusions in respect of this investigation:[39]

> *"**2.75 I do not consider that a professional approach was taken by the police in the preparation of the WN281, WN279 case file.***
>
> *2.76 On the basis of the documents I have seen, it would appear that DCO Harper's forthright interventions were significant and unhelpful. He responded angrily to Simon Thomas's [Law Officers' Department] apparently reasonable suggestion that a little more time should be taken to consider charges. The senior officer had even instructed his officers to get the Centenier in to charge, notwithstanding the advice of Simon Thomas to delay. DCO Harper's approach no doubt contributed to the highly pressured atmosphere in which the other police officers and the lawyers had to operate.*
>
> ***2.77 I conclude that Crown Advocate Baker's Opinion did not address the evidence or the credibility of the complainants in a sufficiently balanced way.***
>
> *2.78 The difficult relations between the States of Jersey Police and the lawyers may account for the rather one-sided assessment of the evidence by DCO Harper on the one hand and by Crown Advocate Baker in his Opinion on the other. DCO Harper's endorsement of the police report of 16 July 2008 reads more as making a case for prosecution than a balanced analysis. Crown Advocate Baker's 5 August 2008 Opinion reads more as a case against prosecution than the comprehensive and transparent opinion he said he was providing.*
>
> *2.79 The evidential situation was not as clear-cut as the analysis in Crown Advocate Baker's opinion suggested. That opinion was at odds with Simon Thomas's early description of the case as being 'finely balanced'. Crown Advocate Baker's assessment of the complainant's credibility was devastating but omitted reference to important information not least the police view that each would be a credible witness.*
>
> *2.80 However, I also conclude that the conclusion reached by Crown Advocate Baker, that the evidential test was not passed in the WN281 and WN279 cases, was reasonable and appropriate given the problems that existed with pursuing the allegations.*
>
> *2.81 Even when one takes a more balanced approach to the evidence and to the issue of the complainants' credibility, there remained real problems with the case, which I have outlined above. This is not a reflection on the complainants' veracity; it is an acknowledgement of the difficulties that existed and their effect when the evidential test was correctly applied.*

[39] WD008989/52–54

2.82 I conclude that the process by which the decision regarding prosecution was made by the Attorney General was appropriate and professional in the circumstances.

2.83 On the basis of the documents that I have seen, it is right to say that the Attorney General in reaching his decision that the evidential test was not met had not simply relied on what Crown Advocate Baker set out in his Opinion. The Attorney General took the opportunity to consider matters further at a case conference on 14 August 2008, at which both the police and the lawyers were present. It was only after this that he came to a final conclusion that no prosecution would take place. I therefore conclude that he properly considered whether this case should be prosecuted, notwithstanding the deficiencies in Crown Advocate Baker's opinion. Note that the case conference

(a) included the key personnel (DC Mark Newman, DS Andy Smith, DS Alison Fossey, DC Shane Evans, Simon Thomas, Steve Baker, John Edmonds, Attorney General);

(b) its stated intention was to allow the Attorney General to reach a balanced decision;

(c) the note of the conference suggest that he was looking beyond the Baker Advice; and

(d) the decision reached was justifiable on the evidence."

11.47 Crown Advocate Baker was invited by the Inquiry to respond to the criticism that his assessment of the issue of witness credibility was not sufficiently balanced. Crown Advocate Baker notes that there was no criticism by Nicholas Griffin QC of the conclusion reached, namely that the allegations in this case did not pass the evidential test. He maintained that his assessment of credibility was justified and said that he fact that no mention was made of the officer's belief as to the witness's credibility "*in no way sustains the suggestion it lacked appropriate balance or objectivity".*[40]

11.48 We agree with Nicholas Griffin QC's analysis and conclusions in the cases of WN279 and WN281. This case highlights a lack of clarity about who was to make charging decisions. We are satisfied however that those considering the charges against WN279 and WN281 acted professionally, despite failings in the preparation of the file. We believe that Crown Advocate Baker's Advice did give at least the impression that his consideration was not balanced, but we take his point that no criticism was made of the ultimate conclusion he

[40] WS000737

reached. We further recognise in particular that the complaints were contradicted by other witnesses who, as children, had been resident in the Home at the same time as the complainants; this would have caused significant problems in any prosecution.

11.49 WN279 was too unwell to give evidence before the Inquiry. WN281 did give oral evidence and denied all the allegations against him and WN279.

11.50 It is clearly arguable from the above that the cases of WN279 and WN281 could have been better handled. However, we have seen no evidence to suggest that any of the decisions taken either by the police or the prosecutors were influenced by any political considerations.

11.51 We also have to consider whether the decisions were taken professionally and competently. We did not hear evidence from Simon Thomas, and are unable to come to a view as to how it was that Lenny Harper understood that a decision to charge had been made before WN279 and WN281 were arrested. However that understanding arose, it is in the nature of complex criminal investigations both that misunderstandings may occasionally arise or decisions may have to be re-visited. We consider that the Advice by Simon Thomas to delay a charging decision until after the police interview was clearly correct, whatever the position had been before that point.

11.52 For the reasons given above, we conclude that the Advice given by Crown Advocate Baker was of an appropriate professional standard; he reached a conclusion properly open to him, although it is regrettable that he did not deal expressly with the counter-balancing arguments.

11.53 We have concluded that the decision taken at the case conference not to prosecute was taken professionally and conscientiously, and that all relevant factors were properly considered.

Alan and Jane Maguire

11.54 This case concerns allegations made by former residents at Blanche Pierre FGH in Le Squez. The allegations arose in the period from 1980 to 1990. A detailed account of events is set out in Chapter 4.[41]

11.55 The Houseparents were Jane Maguire and her husband Alan Maguire. Alan Maguire was not employed by Children's Services but played a role in the running of the Home.

11.56 The allegations were of a regime of repeated and significant physical abuse, including beatings, hitting with a wooden spoon, making the children stand for hours on end as punishment, and washing their mouths out with soap. A number of the allegations were corroborated by entries in a Home Diary (1986–1989) in which the Maguires recorded some of the punishments exacted on the children. Several allegations of sexual abuse by Alan Maguire were also made, but did not result in any charges.

11.57 Allegations of abuse were investigated by Children's Services in 1990, after two former employees became increasingly concerned at the manner in which the children were treated. They approached Children's Services and the Maguires were interviewed. The Maguires made some admissions, including the use of some corporal punishment and washing the children's mouths out with soap. The Maguires were asked to leave Blanche Pierre, and Jane Maguire took up another post in Children's Services. The police were not involved at that stage.

11.58 The first police involvement was in 1997, as a result of an intervention by Children's Services. This coincided with an anonymous threatening letter being sent to Alan Maguire, about which he contacted the police.

11.59 An investigation was then launched, resulting in several complainants and witnesses being interviewed.

11.60 Charges were eventually brought and a committal hearing took place on 8 June 1998. The Magistrate rejected a submission of no case to answer on the

[41] WD007628/328

part of Jane Maguire, and the case was remitted to the Royal Court for trial. Sir Michael Birt QC, the then AG, told the Inquiry that he had no involvement in the case at the time of the hearing before the Magistrate.

11.61 A summary of the circumstances, and the difficulties faced by the prosecution, was set out in a memorandum to the AG from the Force Legal Adviser, Ian Christmas, on 9 October 1998.[42] In that memorandum, Ian Christmas said:

> *"Despite the seriousness of what was alleged, I had grave reservations at the prospect of conviction firstly because of the quality of the victims as witnesses and their age at the time of the allegations, and secondly because of the vagueness of the evidence, the inconsistencies and sometimes absence of corroboration. It was the view of Children's Service and the Police that having steeled themselves to make these complaints, these young victims needed to put these experiences behind them and to be given an opportunity to support a criminal prosecution.*
>
> *The decision, therefore, to prosecute was made without any great optimism that the charges would succeed, but with every hope that the very process by which the allegations came to light and the fact the proceedings were investigated, would allow the victims to come to terms with their past and have confidence that the Jersey authorities had not swept the complaints under the carpet."*[43]

11.62 John Edmonds, in his oral evidence to the Inquiry, was asked to comment on the review, and said:

> *" … It was an inappropriate application of the Code for Crown Prosecutors … I think that's an abrogation of our responsibility as prosecutors, to make decisions on that basis. It's not fair on the witnesses because one provides them with expectations about the state of the case and they will be put through a trial process which is never, or rarely, a satisfactory experience for witnesses, and one can't lose sight of the responsibility one has to suspects, not to put them on trial where there is not a realistic prospect of conviction".*[44]

11.63 Sir Michael Birt QC, in his evidence to the Inquiry, agreed with John Edmonds' view.[45]

11.64 The prosecution was subsequently dropped, the stated reason being that the evidential test was not passed. At the same time, Alan Maguire alleged that

[42] WD009000/369
[43] WD009000/371
[44] Day 126/116
[45] Day 131/9

he was terminally ill with cancer and had a very limited life expectation. (In fact, he survived until 2009.) The Inquiry was provided with documents which set out the prosecutors' decision-making process at that time.[46] The documents included the medical report submitted on Alan Maguire's behalf.

11.65 Sir Michael Birt QC told the Inquiry that it was not common, but not unique, for a prosecution to be abandoned following committal.[47] Subsequently, in 2008, Crown Advocate Baker wrote an Advice in which he said that the prosecution should have been left to take its course.[48] Sir Michael Birt QC disagreed with that view; he said that the prosecution should have proceeded if, and only if, the prosecution considered the evidential test to be met. Since Ian Christmas had raised in his memorandum his concern that the evidential test was not met, the case had to be reviewed.[49]

11.66 Sir Michael Birt QC said that he did not remember the details of the case. He would have read Ian Christmas' memorandum but probably not any of the underlying documents; he would simply have allocated the case to a Crown Advocate.[50] He was shown the medical report submitted on behalf of Alan Maguire. While that did not assist his recollection of the case, he thought that the contemporaneous documents showed that the lawyers decided that the evidential test was not met; Alan Maguire's illness was not a factor in the decision not to pursue the prosecution. He said that he did not know what would have happened had the evidential test been met; Alan Maguire's condition might then have been considered in deciding whether there was a public interest in prosecuting.[51] In a letter dated 6 November 1998 Crown Advocate Binnington (to whom the case had been assigned) wrote:

> *"I have reached the conclusion that it would not be in the public interest for this prosecution to continue further. I reach this conclusion on a review of the evidence … ."*[52]

[46] WD008667/1–55
[47] Day 131/15
[48] WD007233/324
[49] Day 131/16–18
[50] Day 131/20
[51] Day 131/56–58
[52] WD008667/33

and he enclosed a detailed memorandum analysing the evidence in respect of each charge.[53] On review of this memorandum, it would appear that many of the charges, even on Crown Advocate Binnington's analysis, were substantiated.

11.67 Sir Michael Birt QC thought that the reference to the "*public interest*" was an error, since Crown Advocate Binnington went on to apply the evidential test.[54]

11.68 The ultimate decision not to prosecute was taken by Sir Michael Birt QC on 11 November 1998, following a meeting that he held and which was attended by Crown Advocate Binnington, Ian Christmas, Marnie Baudains from Children's Services and two police officers.[55] Sir Michael Birt QC said that it was not usual for him to convene a meeting following receipt of a Crown Advocate's advice; he assumed he had done so because he wanted to satisfy himself that the advice was correct.[56]

11.69 Sir Michael Birt QC, in evidence to the Inquiry, said that, having recently re-read the documents, the characterisation by Crown Advocate Binnington of the evidence in respect of two of the charges (involving washing children's mouths out with soap) as "*extremely weak*"[57] was put "*too strongly*"; the entries in the House Diary and Alan Maguire's own admission provided evidence to support those charges. Sir Michael Birt QC said that he would have tested the views of Crown Advocate Binnington at the November 1998 meeting, but could not recall what was said.[58] He did not think that he would have had the entire file, but would have been reliant on Crown Advocate Binnington's memorandum.[59]

11.70 Sir Michael Birt QC was asked whether, despite his lack of recollection, he thought that the consideration of the case had been approached with an open mind:

[53] WD008667/36
[54] Day 131/79
[55] WD008667/56, 58–59
[56] Day 131/76–77
[57] WD008667/33
[58] Day 131/74–75
[59] Day 131/81

> *"I do. I would say that as strongly as I'm able to and indeed I think it comes through in the note, which says 'no one dissented from this view although naturally there was sadness that this decision had to be taken.'"*[60]

11.71 When his attention was drawn to the report of Nicholas Griffin QC, who concluded that Sir Michael Birt QC had made a proper decision but added that he would have made a different one, Sir Michael Birt QC said:

> *" … clearly when you look at it, it was even then a finely balanced decision. I think that's evidenced by the nature of the memorandum, from Advocate Binnington in particular, who had done a much more thorough review than Ian Christmas -- at any rate the memo was more detailed; the fact that I called a conference clearly suggests to me now that I was uncertain of what the right course was at the time and I think as Mr Griffin says and I would certainly accept: this was a finely balanced decision and inevitably when you get to that sort of stage one prosecutor might say yes and another prosecutor might say no. It's almost the archetypal case where things are close to the margin. So I accept that some other prosecutor might have reached a different decision, but what I would say strongly is that I looked at the evidence at the time that I had, I considered the advice I had, evidence and everything else, and I applied the evidential test as I saw it, and I stand by it being a reasonable decision, one which was open on the facts; I don't say it was the only decision".*[61]

11.72 One of the former residents made a further complaint in 1999 – this time of sexual abuse. This complaint did not result in any charges.

11.73 The case was reviewed as part of Operation Rectangle and the witnesses were re-interviewed. The complainants remained willing to give evidence in the terms set out in their original statements, as did the other potential prosecution witnesses (save one who had died).

11.74 Meanwhile, the Maguires had moved to France. The AG was consulted in 2008 on the question of whether they should be prosecuted. The advice of Crown Advocate Baker was that a prosecution should proceed. Usually, under the practice developed for Operation Rectangle prosecuting decisions, the AG would not be consulted if the advice were to proceed. However, in this instance the circumstances were unusual; prosecutors had to consider the

[60] Day 131/82; WD008667/58

[61] Day 131/87–88

significance and implications of the fact that a previous AG had offered no evidence.

11.75 In a memorandum dated 15 July 2008, in which he sought John Edmonds' advice, William Bailhache QC set out his concerns about the previous decision to offer no evidence. His instinctive view was that the defendants and the public should be able to rely on a decision of a Law Officer and should not expect any successor to resile from that decision, unless it were manifestly wrong or new information had come to light. He set out his opinion that neither of those exceptions appeared to be present in the Maguires' case.[62]

11.76 John Edmonds, in a response dated 21 July 2008, stated that a careful examination of any new evidence would be required, in order to determine whether it could be said to be significant new evidence sufficient to justify charging. He thought that any charges based upon evidence that was available in 1998 would be caught by the original decision not to proceed (and therefore might be regarded as an abuse of process).[63] He then provided an analysis of any changes in the evidence since 1998.[64] His conclusion was that the new evidence did not have a material effect on the overall evidential sufficiency.[65]

11.77 At that point, the AG took advice from First Senior Treasury Counsel in London, Mark Ellison QC. He told the Inquiry that he did so, first, because he knew that the SOJP were very anxious that the Maguires should be prosecuted; secondly, if he did end up supporting the decision of his predecessor not to proceed, he wanted to have an answer to those who claimed that he was just supporting the previous AG as a fellow member of an "*old boys' club*"; thirdly, he knew that the case had been the subject of one of Stuart Syvret's complaints to the Ministry of Justice, and he thought that there was a possibility of the subject being reopened. He also recognised that he, reviewing a decision of a previous AG and perhaps concerned that his own

[62] WD009017/616, Day 128/138
[63] WD009017/622, WS000701/75–77
[64] WD007627/2
[65] WD007627/5/13

decisions might be reviewed, might be "*too close*" to make an objective decision.[66]

11.78 William Bailhache QC said that he also tried (although failed) to see the AG and the SG (of England) but obtained a view from the Principal Legal Adviser to the Crown Prosecution Service.[67] William Bailhache QC told the Inquiry: *"It was a difficult case and I just wanted to consult as widely as I could about it."*

11.79 Mark Ellison QC concluded:

> *"25. Assuming that the circumstances cannot be brought within the availability of a formal plea of autrefois acquit,*[68] *the strength and nature of the representation made by the prosecution in 1998, that there was insufficient evidence to justify the case proceeding despite the Magistrate having committed the defendants for trial, was such that an abuse of process application on the basis that it would not be fair or a proper use of the court process to allow the prosecution to reinstitute proceedings ten years later is highly likely to succeed unless there were the most exceptional circumstances, such as very compelling and completely new evidence capable of removing the reasons for the 1998 decision and having a good reason for not having been available before.*
>
> *26. The material provided to me clearly falls far short of providing any such exceptional justification.*
>
> *27. In my assessment the material provided indicates that it would not be proper for the Attorney General to seek to reinstitute criminal proceedings against Alan or Jane Maguire.*
>
> *28. Even if such compelling new evidence were to exist and proceedings might therefore be properly reinstituted, or if there was new evidence capable of supporting a fresh charge or charges, there is still a significant risk that the prosecution would be unable to counter the inevitable abuse of process application based more generally upon the impact of delay on possibility of holding a fair trial, resulting in proceedings being stayed."*[69]

11.80 The AG also obtained an Advice from Richard Latham QC, of 7 Bedford Row, London, as to whether Alan Maguire should be prosecuted for sexual offences (which were not charged in 1998, although the evidence in respect of all but one complainant was available). He concluded that the evidential test was not

[66] Day 128/140–141

[67] Day 128/141–142, 149; WD009017/662

[68] A plea of previous acquittal, preventing prosecution

[69] WD009017/640

met and also referred to the risk of an abuse of process argument. He stated that the public interest test would be satisfied if the evidential test were met. He referred, in general terms, to the pressure to give a complainant his or her day in court but said that to compromise the evidential test to allow tenuous cases to proceed was improper. He also added the following warning:

> *"28. I am well aware that there is a similar pressure manifest in Jersey as a result of a number of investigations into historical allegations of child abuse. To litigate this case and fail, and particularly to fail at the stage of an examination of whether or not mutual corroboration existed, would be a very unsatisfactory resolution of this file. The adverse ramifications of the inevitable attendant publicity might put at risk any subsequent stronger cases which have yet to be considered."*[70]

11.81 William Bailhache QC told the Inquiry that this advice was the same as that given to him earlier in the year by Crown Advocate Baker with which he agreed, that the strongest cases should be brought first because, if this did not happen, there was a real risk that all of the prosecutions would fail.[71]

11.82 William Bailhache QC said that, having received all of this advice, he believed that he had explored sufficiently the prospect of prosecution. However, at a case conference in September 2008, DSupt Michael Gradwell asked for more time to go to France to interview the Maguires. An admission of guilt might have amounted to the special circumstances needed to reopen the prosecution. William Bailhache QC said that he therefore agreed to give the police the opportunity to try to arrange an interview. He understood that, in the event, Alan Maguire refused to see the police.[72]

11.83 Michael Gradwell told the Inquiry that the case conference took place very soon after he had arrived in Jersey. The Law Officers proposed that there should be no further action. However, Michael Gradwell realised that the Maguires had not been interviewed and that there were other lines of enquiry that could be pursued. He persuaded the Law Officers to give the SOJP more

[70] WD009017/659
[71] Day 128/148
[72] Day 128/147–148

time to conduct further enquiries. He told this Inquiry that it was very easy to persuade the Law Officers to agree to this course.[73]

11.84 The case was considered again on 9 March 2009, at a meeting attended by William Bailhache QC, Crown Advocate Baker, John Edmonds, DSupt Michael Gradwell and DI Alison Fossey. The AG by this point had to decide whether to seek the Maguires' extradition from France, and had invited comments from the police. The police were aware that the AG's instinct at this stage was not to pursue a prosecution.

11.85 The AG raised again his concern at the prospect of overturning a decision of a previous AG when he could not say that that decision was clearly wrong: *"If there were five or six complainants here who might feel that they had had a raw deal at the instance of the criminal justice system, the position was far worse for all those people who in the future might be told that no action would be taken against them, because they would not be sure whether to believe it or not. The state of uncertainty which would be introduced into the public mind as a result of knowing that the Attorney General could, on a whim, change a decision of a previous Attorney General seemed to me to be very undesirable from a public policy perspective."*[74]

11.86 The AG also told the meeting that he believed that abuse of progress arguments "*would be very strong indeed*". He did say, though, that had he been taking the decision afresh, with "*no previous baggage*", then he probably would have prosecuted.[75]

11.87 In his evidence to this Inquiry, William Bailhache QC emphasised that, while he would probably have prosecuted, *"sometimes these are fine judgment calls. This was one of those cases where different people would take different views … You can't say either [he or his predecessor] was right or wrong on it"*.

11.88 John Edmonds, in his statement to the Inquiry, said:

> *"I have been asked whether the decision not to prosecute the Maguires was influenced by anticipated arguments of abuse of process or by*

[73] Day 111/99–200
[74] WD009017/672–673
[75] WD009017/673

embarrassment at the prospect of overturning the decision of Michael Birt QC. The decision not to reinstitute proceedings against Alan and Jane Maguire was all about making the right decision. If the right decision meant having to overturn the previous Attorney General's decision and having to deal with an abuse of process argument, then we would have done that. You cannot be swayed by public opinion; the easy decision would have been to prosecute, since that was, in many ways, the line of least resistance. One should not take a decision on the basis that is the easy decision; we have a public responsibility and are paid to make difficult decisions. In short, we have to make the decision that is right and which will survive objective scrutiny."[76]

11.89 No further charges resulted from Operation Rectangle, and the Maguires were never brought to trial. They remained in France until Alan Maguire's death in 2009.

11.90 Michael Gradwell told the Inquiry that he believed that the decision not to prosecute was a proper one; his recollection was that it was, though, the opinion of all involved that the Maguires should have been prosecuted at the time of the first investigation in 1998.[77]

11.91 Michael Gradwell told this Inquiry that, in all of his discussions with the Law Officers and legal teams about proposed prosecutions, although the lawyers would have formed a view of the case, they were always open to discussion. He had no concerns that they were acting anything other than professionally.[78]

11.92 Nicholas Griffin QC, independent leading counsel, reached the following conclusions in respect of the Maguire case:[79]

"Conclusions: 1997 to 1998 investigation

3.93 I conclude that the preparation of the case file was carried out to a professionally competent standard by the Police.

3.94 The relevant chronology for these purposes was as follows. In May 1997, the Children's Services contacted Police Headquarters about suspected child abuse by Jane Maguire. Alan Maguire was also suspected of child abuse. In the same month, Alan Maguire reported to the police a threatening letter he had received. Thereafter, WN76 came forward with her complaints and other ex-residents and staff were

[76] WS000698/46/138
[77] Day 111/100–101; WS000658/35
[78] Day 111/108–109
[79] WD008989/96–103

spoken to. In December 1997, Ian Christmas was first alerted to the investigation and in February 1998 time-barred cruelty charges were formulated, probably by Ian Christmas. New assault charges were substituted in April 1998. The focus of the charges was on certain aspects of alleged physical abuse. Allegations of sexual abuse were not charged. The committal took place in June/July 1998. In August 1998 A/PS Troy provided his report and in September 1998 Ian Christmas's office received what he described as the 'case file'. Clearly, Ian Christmas had been in receipt of evidence and information prior to this to allow him to advise about and formulate the charges. In October 1998, he provided his memorandum and in November 1998, Crown Advocate Binnington provided his letter and review.

3.95 The Police had obtained significant evidence, had liaised with the Legal Adviser about charges and had submitted a case file post committal for consideration by Ian Christmas and also Crown Advocate Binnington, which permitted them to conduct a further review of the evidence at that stage. On the basis of the information available to me, I therefore conclude that the police had properly and professionally prepared the case file and forwarded it for consideration.

3.96 The roles played by Ian Christmas and Crown Advocate Binnington and the Attorney General's decision to discontinue the case have been the subject of criticism by others who came to consider the case after them:

3.96.1 In a May 2008 report, DCs Holmes and Newth concluded that the Attorney General's 1998 decision to halt the prosecution had been wrong and even that: "Clearly, based solely on the information to hand questions must be raised as to the motivation of prosecution of this case to succeed as on the face of it, despite clear difficulties with the case the prima facie evidence was there for this matter to go to trial". Their report was endorsed in manuscript by Deputy Chief Officer Lenny Harper. His comments included that: 'I agree with all that the reporting officers have "flagged up" and consider that a great injustice was perpetrated on the victims in this case. This will just be exacerbated should the system fail again … '

3.96.2 In his July 2008 Advice, Crown Advocate Baker was also critical of the approach taken in 1998: 'These charges had been committed to the Royal Court. Undoubtedly the procedure should have been left to take its course. The intervention by Ian Christmas will not be easy to justify. The opinion prepared by Crown Advocate Binnington in 1998 appears to conflate the public interest and evidential tests and places some reliance on what was thought then to be the extremely limited life expectancy of Mr Maguire, a prophecy which has not come to pass.'

3.96.3 In March 2009, John Edmonds, Principal Legal Adviser at the LOD [Law Officers' Department], considered that: 'We are handicapped by the 1998 decision. If this came to us as a new case, I believe that we would identify those complainants who appeared credible and

prosecute both the physical and sexual abuse allegations which they made'.

3.97 I have considered that these criticisms are valid in part and that the approaches of Ian Christmas and Crown Advocate Binnington were flawed.

***3.98 I conclude that Ian Christmas was unclear about the correct tests to apply when considering the question whether to prosecute**.*

3.99 As I noted in the introduction, the Code on the Decision to Prosecute came into existence only in January 2000. I have not been provided with information to show precisely what happened before that date. However it is clear from other documents from 1998, that the Law Officers' Department was at that time using and applying the dual evidential and public interest test. See, for example the Attorney General's File Note of 11 November 1998 in Alan and Jane Maguire's case. It recorded the conclusion that there was 'insufficient evidence to have any realistic prospect of a conviction' in that case and further noted that the 'public interest test only came into effect where there was sufficient evidence'.

3.100 Ian Christmas had proceeded with charges against Alan and Jane Maguire in the face of what he took to be weak evidence in order to provide the complainants with a form of catharsis and to avoid the suggestion of a cover-up. If he really did have 'grave reservations as to the prospect of conviction' and made the decision to prosecute 'without any great optimism that the charges would succeed' he was clearly applying the wrong evidential test in order to let the case proceed charge and committal.

3.101 I conclude that Ian Christmas gave insufficient thought to the appropriate charges to bring to reflect the physical abuse allegations.

3.102 Time-barred offences were incorrectly charged initially, reflecting an unfocused approach from the start. Thereafter, assault charges were brought which reflected the stronger evidence in some cases but not in others which included certain weaker allegations that arguably did not meet the correct test.

3.103 I conclude that the decision not to charge allegations of sexual abuse was justifiable in the circumstances and when the correct evidential test was applied.

3.104 This is for the reasons given in the advices of Crown Advocate Baker and Richard Latham QC.

3.105 I conclude that Crown Advocate Binnington confused the evidential and public interest tests when considering whether the prosecution should proceed post-committal.

3.106 Crown Advocate Binnington's letter to the Attorney General indicated confusion in his mind about the proper application of the separate evidential and public interest tests. He had said: 'it would not be in the public interest for this prosecution to continue further. I reached this conclusion on a review of the evidence ….'

3.107 He had placed reliance on the public interest factor of Alan Maguire's health, on the basis of medical reports that cannot now be found[80] *and in circumstances where Alan Maguire went on to live for another decade.*

3.108 I have reached different conclusions from Crown Advocate Binnington in my assessment of the strength of the evidence in respect of certain of the charges. I have concluded that some passed the evidential test (e.g. involving the use of soap).

3.109 I acknowledge that the body of evidence in support of Alan and Jane Maguire presented difficulties to a prosecution. In my opinion, they were not necessarily insurmountable. So, for example, it may be that the Blanche Pierre regime changed for the worse over time, explaining why former residents such as 247 and 248, who are older and who had been present there at an earlier stage, said that they did not experience abuse. Furthermore, WN307's evidence was contradicted by the Blanche Pierre diaries and even by Alan Maguire's admissions at interview.

3.110 I conclude that the flaws in the approach of Ian Christmas and Crown Advocate Binnington were addressed by the Attorney General; I have ultimately concluded that the decision-making process he adopted was appropriate and professional in the circumstances.

3.111 The then Attorney General, Michael Birt QC, concluded that the evidential test was not met in respect of any charges that had been committed to the Royal Court. This was a significant decision to have reached in circumstances where there had been a committal with consideration of the evidence by a Magistrate. However, I also note that the situation was not straightforward:

3.111.1 Ian Christmas had not properly applied the evidential test prior to drafting the charges (it seems to have been his view that the evidential test was not in fact met);

3.111.2 there was concern that Judge Trott had not properly considered the evidence at committal and had permitted charges to be committed where there was no/little evidence in support; and

3.111.3 the test applied in a no case to answer submission at committal (as was made on behalf of Jane Maguire) was whether the

[80] The Inquiry was subsequently provided with a contemporaneous medical report. It was made available to Nicholas Griffin QC before he gave oral evidence

prosecution could make out a prima facie case and is not the same as the realistic prospect of conviction evidential test.

3.112 I have ultimately concluded that the Attorney acted to a professionally competent standard for the following reasons:

3.112.1 whilst the Attorney General had referred to the letter and memoranda provided by Ian Christmas and Crown Advocate Binnington, he had also conducted a review of the evidence during a case conference;

3.112.2 he went on to apply the dual evidential test and public interest test in reaching his decision, identifying where Crown Advocate Binnington had fallen into error and apparently not taking into account the suggested poor health of Alan Maguire; and

3.112.3 this was a difficult case involving conflicting evidence in which a competent specialist prosecutor could logically have reached the same decision as the Attorney General.

3.113 This has been a finely balanced conclusion, in a case where I would have reached different decisions on the evidence. However, the test I apply is not what I personally would have done in the circumstances but whether the decision-making process was appropriate and professional, applying the test of the competent specialist prosecutor.

3.114 It has been suggested that DC Troy disputed that the case conference actually took place. It would be necessary to revisit this conclusion if further information came to light indicating that the Attorney General's file note of the case conference was not accurate.

Conclusions: 1999 investigation

3.115 I conclude that the preparation of the further case file and the process by which the decision was taken not to prosecute WN81's 1999 allegation of sexual abuse were both to a professional standard.

3.116 There were real problems in continuing an investigation in the circumstances that then existed on the basis of WN81's 1999 evidence. This was primarily because:

3.116.1 she had gone on to [REDACTED] when one might have expected her to have taken that opportunity to distance herself from them;

3.116.2 she had not previously mentioned the sexual abuse when speaking to the police, although she knew that others were making such allegations. Indeed, she was expressly asked during her 1997

interview why she thought this had not happened to her, to which she replied 'I don't know'; and

3.116.3 it was only following the decision to discontinue proceedings that she came forward with these further allegations.

Conclusions: Operation Rectangle

3.117 I conclude that the preparation of the Operation Rectangle case file and the decision making process regarding prosecution were to a professional standard.

3.118 Before reaching a final decision, the Attorney General sought advice from Crown Advocate Baker, Queen's Counsel in London and his own legal adviser, John Edmonds. The advice received covered competently and in detail the question of evidential sufficiency, the application of the public interest test but also important and difficult questions of law.

3.119 There is no doubt the proper consideration was given whether to prosecute the case at this stage."

11.93 The Panel concludes that the decision in 1998 to abandon the prosecution was ultimately taken professionally. The Panel notes the following matters:

- In deciding to prosecute, Ian Christmas applied the wrong test. He appears to have believed that the evidential test was not satisfied, yet pursued prosecution to give the complainants their "day in court".
- The decision to abandon the prosecution, despite Judge Trott having ruled that there was a prima facie case, was one that could properly be reached, even though another prosecutor may have made a different decision. We accept that the AG conducted an appropriate review of the case and reached a decision that was, on the material before him, open to him.

11.94 The Panel concurs with the view of Nicholas Griffin QC that the decision not to prosecute in 1999 was professionally taken. The factors that he listed (and which are set out above) would have caused substantial difficulties in any prosecution, and those difficulties were correctly identified and properly addressed.

11.95 The decision in 2008 not to proceed was properly and professionally taken. The Panel notes that:

- The decision was clearly taken with the utmost seriousness. The AG obtained advice from two Queen's Counsel in England, as well as the Principal Legal Adviser of the CPS;
- There is a clear public interest in people being able to rely on the decision of prosecutors not to bring a prosecution. That public interest may be outweighed, in some cases, by the countervailing public interest in offenders being brought to justice (although that will not be a decision for the prosecutor alone. It will almost always be open to a defendant to argue before the Court that prosecution following an announcement of a decision not to prosecute would be an abuse of process);
- Prosecution following an announced decision not to prosecute may be justified when significant new evidence emerges. We agree with the view expressed by prosecutors and Mark Ellison QC that such new evidence did not exist. Whether we agree is, in any event, too high a test. The test that we have to apply is whether the view was reached professionally, and we believe that it was;
- In this case, the decision that the public interest in upholding the decision of a previous AG was professionally reached.

WN7

11.96 In 2004, allegations of physical assault on children at La Preference were made against WN7, a member of staff. These allegations concerned two residents in the early part of that decade, and one individual who had been resident in the 1980s. No prosecution followed.

11.97 WN7 also worked at HDLG and Les Chênes. In the course of Operation Rectangle, allegations of physical and sexual assault were made against him by a further ten complainants, and two other potential victims (by then deceased) were identified.

11.98 John Edmonds considered the file and, on 8 April 2009, wrote a memorandum to the AG in which he concluded that the evidential test was not passed in

respect of any of the allegations.[81] He told the Inquiry that Baker Platt would always send a copy of each Advice to the SOJP so that factual inaccuracy could be identified and corrected. Baker Platt would have advised in this case.[82]

11.99 In this case, a number of the complainants were assessed to be unreliable. John Edmonds was asked, during his oral evidence, whether that assessment in respect of some witnesses would influence his view in respect of others. He said:

> *"Not unless there was evidence of collusion. The fact that individual A – and let's assume that the facts are as they are set out in [paragraph five of his memorandum] – individual A is wrong because they were not at Haut de la Garenne at the same time, that wouldn't influence a decision being made in respect of a wholly unrelated complaint. In fact one would actually be looking at it the other way: if we had a number of witnesses who were making a complaint of a similar conduct in relation to a defendant, they would support each other; we would be looking at it from that point of view rather than saying 'Well, X has made something up against this individual, therefore everybody else who has made a complaint against his individual would be wrong.' That seems to me to be intellectually flawed, to approach a case from that point of view."*[83]

11.100 The AG accepted John Edmonds' advice, and there was no prosecution in 2009.

11.101 Nicholas Griffin QC was unable to reach a conclusion in respect of the decision in 2004 not to prosecute. The brief memorandum from Laurence O'Donnell, Force Legal Adviser, in which he advised against prosecution, made no express reference to one of the complainants (although Laurence O'Donnell did say that his conclusion applied to "*all allegations contained within the file*"). Nicholas Griffin QC stated that the memorandum should have addressed the allegations of this complainant. He was unable to be sure whether Laurence O'Donnell had received an incomplete file or had failed to make reference to information that was available to him. Nicholas Griffin QC said:

[81] WD008792
[82] Day 126/131
[83] Day 126/132

> *" … I believe that Laurence O'Donnell probably did consider this evidence … but I am unable to reach a definitive conclusion about this. In such circumstances I am unable to come to a conclusion whether the decision-making process was appropriate and professional".*[84]

11.102 During Operation Rectangle, the AG issued a press statement stating that there would be no prosecution of WN7. After that press release had been issued, Crown Advocate Baker provided further advice on prosecution. Nicholas Griffin QC could not tell from the papers supplied to him whether the Law Officers had gone on to consider the second advice, and so could not say whether a professional approach had been adopted in relation to it. However, he believes it highly unlikely that the content of the advice would have made a difference to the decision not to prosecute:

> *" … having reviewed the underlying evidence myself, it seemed highly unlikely that that would have resulted in a different conclusion as to evidential sufficiency".*[85]

11.103 He concluded that in all other respects a professional approach was taken in case preparation and decision making.

11.104 Like Nicholas Griffin QC, and for the same reason, we believe that it would be unfair for us to reach a view on the decision-making in 2004. However, we believe that the decision in 2009 was taken professionally. The advice from John Edmonds was consistent with that from Baker Platt. John Edmonds impressed the Panel as a witness, and we have no doubt that he approached this decision, and all of his work, with complete integrity and a high degree of professional competence.

<u>WN491</u>

11.105 This case involved allegations that WN491, a member of staff at HDLG, physically assaulted children in his care. One allegation was that he used to flick boys with wet towels (sometimes knotted) in the showers, leaving welts. The complainants' evidence was that WN491 was not engaging in horseplay but was trying to hurt and humiliate them, and did so.

[84] WD008989/136

[85] Day 133/68/25–69

11.106 The decision was taken not to prosecute. The allegations were investigated by Operation Rectangle in 2008–2009 but not earlier. In respect of all the allegations, other than the towel flicking, Nicholas Griffin QC considered that a competent and professional approach was taken in respect of case preparation, that the decision not to prosecute was appropriate and professional, and that the decision was made for the reason stated, namely that the evidential test was not met.[86]

11.107 In respect of the towel-flicking allegation, Nicholas Griffin QC concluded that the AG again reached a competent decision, and did so professionally, but that the true reason for not proceeding was not the stated reason of the evidential test not being made out, but that prosecution of these relatively minor and very old matters was not in the public interest.[87]

11.108 The evidence from those involved in making the decision was that it was not made on public interest grounds but that the evidential test was not passed. William Bailhache QC explained:

> *" … there are circumstances in which the public interest can affect the assessment of the evidential test as well … the evidential test is whether, properly directed as to the law, a jury is more likely than not to convict, so a prosecutor looks at what a jury is going to make of a prosecution case … and if it's a case which is 30 years old … It may not be in the public interest to prosecute that … it's also possibly not going to beat the evidential test because you know a juror is going to say 'Was it really an assault?' Was there that malicious a criminal intent which is necessary … to bring a juror to the point of convicting?"*[88]

11.109 In concluding that the AG's approach, in reaching his decision with regard to the towel flicking allegations, was appropriate and professional in the circumstances, applying the test of the competent prosecutor, Nicholas Griffin QC said:

> *"I conclude that this test is passed … In my opinion it was legitimate for the Attorney General to find that there were public interest reasons against prosecution, in circumstances where the allegations in question*

[86] Day 133/77–78; WD008989/228

[87] WD008989/229; Day 133/78–83

[88] Day 128/32

were in some instances over 40 years old, the defendant was elderly and further the court might impose a nominal penalty on conviction."[89]

11.110 The panel is satisfied that, even if Nicholas Griffin QC is correct that the decision was made on public interest grounds, rather than on the evidential test, it is a decision which was professionally reached in the circumstances.

11.111 This is an example of the sort of case in which lawyers may disagree over whether the test being applied is the evidential test or the public interest test. While we agree with Nicholas Griffin QC's interpretation of the law on this issue (summarised above), we have no doubt that the AG acted in good faith in concluding that the evidential test was not met. We conclude that the decision not to prosecute was one that could lawfully and properly be reached, for the reasons given by those involved.

WN246

11.112 Allegations of physical assaults on children were made against WN246, a teacher at Les Chênes. One allegation, involving an alleged assault on one child some 15 or 20 years earlier, was made and investigated in 1999. Nicholas Griffin QC said that he was unable, on the information available to him, to reach any conclusions as to the standard of case preparation or decision-making. A police report stated that enquiries were ongoing, but no further material was available.[90]

11.113 Further allegations were investigated as part of Operation Rectangle. These allegations were much wider, and involved five additional complainants, who made a total of seven additional complaints of physical assault. The police also obtained evidence from former residents who spoke of other children being physically assaulted, but the reported victims did not confirm the accounts. The Police advised against prosecution; they recorded that WN246 denied the allegations, that only two of the allegations made by the six complainants were corroborated at all by the accounts of other residents, and that that corroboration was in some respects at variance with the alleged victims' accounts. DI Alison Fossey, agreeing with the view of the

[89] WD008989/154

[90] Day 133/83–85; WD008989/171

investigating officer, concluded that the evidential test was not met. Two members of Baker Platt advised (William Redgrave, an Associate with Baker Platt, and then Crown Advocate Baker), and supported the Police view; Crown Advocate Baker noted that there were no contemporary records of complaints, and no supportive medical evidence. He emphasised that he was not seeking to say that the complainants were lying; it did appear that WN246 had routinely assaulted residents. However, he concluded that the evidential test was not met in respect of the specific allegations that he was considering. The AG and John Edmonds reviewed the file and reached the same conclusion.

11.114 Nicholas Griffin QC queried the basis on which the decision was taken not to prosecute WN246 for having poured chocolate mousse over a boy's head. There was corroborative evidence for what would have been a memorable incident, and WN246 had himself told the police that it *"rang a bell"*. Crown Advocate Baker, in his Advice, concluded that the evidential test was not met in respect of any of the allegations. However, when dealing specifically with the chocolate mousse incident, he noted that there was corroboration but went on to say that it would not have been in the public interest for a prosecution to be brought; it would expose the prosecution process to ridicule. Nicholas Griffin QC concurred with the view that, if the evidential test were met, the public interest test would not have been satisfied. He concluded that case preparation and decision-making were competent, appropriate and professional.[91]

11.115 We, like Nicholas Griffin QC, do not have sufficient material available to us for us to reach any conclusions about the investigation in 1999.

11.116 In respect of the Operation Rectangle investigation, we believe the police to have conducted a thorough inquiry. Attempts were made to obtain corroboration, and a substantial number of residents interviewed. It was always going to be very difficult to obtain reliable evidence of individual assaults said to have occurred very many years earlier, particularly against what appears to have been a background of routine assaults. It is

[91] WD008989/172–173

unsurprising that residents' accounts were vague or inconsistent, but that very vagueness and the lack of corroboration clearly presented significant difficulties both for the officers and for those who had to make prosecuting decisions.

11.117 We conclude that the decisions not to prosecute were competently and professionally made. In respect of the chocolate mousse incident, it is clear to us that the evidential test was satisfied, and that that must have been apparent to those who decided not to prosecute. The decision not to do so was, we believe, made on public interest grounds.

11.118 While we believe that decision to have been taken professionally, we have to consider it against the evidence given to us that all decisions not to prosecute were made on evidential grounds. The evidence to us on this issue from William Bailhache QC was:

> *"I think one has to have regard to whether a charge – whether a jury properly directed as to the law would be more likely than not to convict on the charge, so they may well have been satisfied that the bowl of chocolate mousse was poured over his head, maybe, I don't know, but the chances of getting a conviction seemed to me to be remote. Now, that is an example of perhaps the difference that I have between that and Mr Griffin. He regards that, as I understand it, as being purely a public interest matter. I think that it is both, it's both a public interest and an evidential test."*[92]

11.119 Again, we conclude that this is a case in which different lawyers have, honestly and professionally, reached different views as to the characterisation of the test. While we prefer Nicholas Griffin QC's interpretation of the law, we have no criticism to make of the decision taken by the AG.

<u>WN335</u>

11.120 In this case, allegations of sexual abuse by a member of staff at Heathfield were made and investigated in 1991. Ian Christmas, Force Legal Adviser, took the decision not to prosecute, largely on the basis of his view that the complainant lacked credibility that there was no corroborative evidence, and

[92] Day 126/134

that WN335 had denied the allegations.[93] Nicholas Griffin QC considered that a competent and professional approach was taken in the preparation of the case file and that the decision not to prosecute was appropriate and professionally taken. He queried whether other residents of Heathfield should have been approached, in an effort to see whether corroboration could be obtained. However, he concluded that this issue was outside the scope of his instructions.[94]

11.121 The allegations were considered again as part of Operation Rectangle. By this time the complainant, WN216, said that he did not wish to assist any police enquiry. Forensic examination of a bed sheet (from 1991) provided no useful evidence, and the decision not to prosecute was taken under the matrix system adopted by the Gold Group sub-panel. Nicholas Griffin QC concluded that the decision was taken professionally and appropriately. He reached no conclusion on the case preparation by the police because the decision not to prosecute was taken before the case file was complete. (Nicholas Griffin QC had no criticism to make of the timing of the decision.[95])

11.122 We have addressed in Chapter 10 the two police investigations. We concluded that the police made proper efforts during Operation Rectangle to obtain corroborative evidence and we had no material on which we could criticise the investigation in 1991. We agree with the opinion of Nicholas Griffin QC that the decisions of prosecutors both in 1991 and during Operation Rectangle were taken professionally and competently. By the time of the latter investigation, WN216 was not willing to give evidence and no corroborative evidence could be found; the decision not to prosecute was, in our view, not only one that could properly be taken but was inevitable.

Les Hughes

11.123 Les Hughes was prosecuted in 1989 and pleaded guilty to sexual assaults on three female residents of Clos des Sables, where he was the

[93] Day 133/86; WD008989/181

[94] WD008989/185–186

[95] Day 133/86–87; WD008989/187–188

Housefather. Nicholas Griffin QC concluded that the preparation of the case file and the decision to prosecute were competent and professional.[96]

11.124 Further allegations against Les Hughes were considered as part of Operation Rectangle. The Gold Group sub-panel decided, before preparation of the case file was complete, not to proceed with a prosecution.

11.125 The sub-panel decided not to prosecute, for the following reasons:

- the allegations were not of the most serious nature; and
- Les Hughes was 82 years old, did not appear to have re-offended since 1989 and the risk of re-offending was minimal.

11.126 Chief Inspector Cane concluded that prosecution "*is not in the public interest*". DCI Alison Fossey endorsed that conclusion: "*Agree. NFA".*[97]

11.127 Nicholas Griffin QC expressed no opinion, in these circumstances, on the preparation of the case file. He concluded that the decision not to prosecute was appropriate and professional.[98]

11.128 We concur with Nicholas Griffin QC's view. It is obviously inappropriate for any criticism to be made of a case file left incomplete because a decision not to prosecute meant that no further investigations were pursued. We also agree that the decision not to prosecute was a professional one, taken for legitimate reasons.

<u>Anthony Watton</u>

11.129 The SOJP investigated complaints against Anthony Watton on a number of occasions. He was convicted of indecent assault in 1987 and charged again in 2001. He took his own life before the matter came to court. When further complainants came forward during Operation Rectangle, Anthony Watton had been dead for seven years.

11.130 Nicholas Griffin QC concluded that a competent and professional approach was taken in the preparation of the case file in 2000/2001. He stated that

[96] WD008989/203
[97] WD008989/202–203
[98] WD008989/204

there was insufficient information to enable him to reach a view on the Operation Rectangle investigation or earlier investigations:

> *"I don't here make any adverse findings at all. This is a criminal investigation that's been conducted … seven or more years after the death of the main suspect, so the fact that there was no file or decision as to charge is understandable in those circumstances."*[99]

We concur with Nicholas Griffin QC's views, and have no criticisms to make. We do not have sufficient information on which to base any detailed finding. However, we do not criticise the decision taken during Operation Rectangle not to allocate substantial resources to an investigation into alleged offending by a man who was dead and could obviously not be prosecuted.

Other investigations considered in Operation Rectangle

Mr and Mrs Jordan

11.131 The case concerned allegations of physical abuse of children at HDLG by two members of staff. Morag Jordan was employed there from 1970 to 1984 and Tony Jordan from 1978 to 1984. The allegations were that they routinely hit the children with a hand or wooden spoon to the face, arm or leg, and pushed children's faces into urine. Complaints were made that Morag Jordan had assaulted nearly 30 children. The evidence painted a picture of a regime of sustained cruelty.

11.132 Crown Advocate Baker advised that, because of the relatively minor nature of the assaults, prosecution was not in the public interest. He raised the possibility that some – but certainly not all – of the assaults might have been regarded as lawful chastisement at the time. He was overruled by the AG. The decision to prosecute was made after a discussion on 23 October 2009 over the public interest question, involving the AG, Crown Advocate Baker, John Edmonds and DI Alison Fossey.[100]

11.133 William Bailhache QC noted:

> *"In principle it is agreed that the public interest is passed because of the sustained oppressive regime, the fact that this was not an*

[99] Day 133/94
[100] WD009017/676–677

occasional lapse of judgment and that there was [sic] *some serious incidents."*

11.134 In his oral evidence to the Inquiry he said that he also had in mind the fact that he had stated that there would have to be some special public interest reasons not to prosecute the Rectangle cases and no such reasons were present.[101] Tony and Morag Jordan were prosecuted and received custodial sentences.

11.135 We find that Crown Advocate Baker advised competently and professionally. The issue as to whether the public interest test was met was a matter of judgment in which different prosecutors could legitimately reach different views. We also find that the AG's decision to prosecute was reached professionally and properly. It appears to be an example of the implementation of his policy to pursue Rectangle prosecutions when the evidential test was met, in the absence of compelling public interest reasons not to do so.

Mario Lundy

11.136 William Bailhache QC said that the case was obviously sensitive as, when the allegations arose in 2007/2008, Mario Lundy was the Director of Education. A total of 27 complaints of physical assault had been made against him, ranging from allegations that he had punched and caned children to accusations that he had thrown children against walls, while Deputy Principal of Les Chênes. Crown Advocate Baker advised that there were substantial evidential difficulties, including the fact that the allegations were very old and memories might not be reliable, attitudes to the treatment of children were different in the 1980s (the time of the alleged offences) from attitudes 20 years later, that a Court might have sympathy for staff members dealing with unruly teenagers, that the prosecution would have to disclose evidence from residents who contradicted the picture of a violent regime painted by the complainants, and that some of the complainants could be portrayed as difficult and challenging children.[102] When Crown Advocate Baker and John Edmonds advised that the evidential test was not passed he

[101] Day 128/66/116
[102] WD007970/15

decided that the case needed to be reviewed by independent leading counsel.[103] John Edmonds said that this was helpful:

> *" …. it provided advice from somebody – from people who had no connection with Jersey--- independent, robust advice …. If we were making a decision that was not correct we wanted people who would tell us that".*[104]

11.137 Martin Meeke QC, an experienced prosecutor in child abuse cases, was instructed. He agreed that the evidential test was not met. The AG accepted that advice and advised the police there was insufficient evidence to justify charging Mario Lundy.

11.138 On 7 August 2009, John Edmonds wrote to the Education Department to inform the Department that there would be no prosecution. He also advised that the Department should seek "*relevant disclosure*" from the police. The purpose was (1) invite the Department to seek disclosure of material from the police for the protection of children with whom Mario Lundy might come into contact, and (2) to enable the Department to obtain police documents for use in any disciplinary proceedings.[105]

11.139 The Panel considers that an appropriate and professional approach was taken by those making the decision whether or not to proceed to prosecution. It is clear that the matter was considered in great detail, initially by Crown Advocate Baker and John Edmonds. William Bailhache QC, aware of the sensitivities, acted entirely properly in obtaining independent legal advice. The fact that disquiet remained is reflected in John Edmonds' invitation to the Education Department to seek police disclosure for child protection purposes. That disquiet could not, of course, justify a prosecution if the evidential test were not met.

<u>WN108</u>

11.140 In 2009, 11 allegations of physical abuse were made against a member of staff at Les Chênes, relating to incidents said to have occurred between 1977 and 1988. The allegations were considered in tandem with those made

[103] Day 128/93–94
[104] Day 128/32
[105] Day 12 all 6/132–133; WD0089896

against Mario Lundy. The Police did not believe the evidential test to be met. They recorded that the allegations were uncorroborated, that other residents at the Home had nothing but praise for the alleged offender and that there was a possibility that one former resident was trying to cajole others into making false complaints in order to gain compensation.[106] Crown Advocate Baker advised that there was no corroborative evidence to support most of the allegations. Some of the complaints referred to excessive use of the cane. Crown Advocate Baker concluded that a court would be unwilling to convict a defendant for using a cane at a time at which corporal punishment was lawful. He noted, in respect of some of the other allegations, that the credibility of the complainants was in doubt. In some instances, residents alleged by a complainant to have witnessed an assault would not support the allegation. Some residents gave positive accounts of the alleged offender. Crown Advocate Baker considered that only one of the allegations merited serious consideration, and that one did not meet the evidential test.[107]

11.141 We consider that the decision not to prosecute was professionally made. Crown Advocate Baker had available to him the results of the police investigation, which had been thorough. The police had made every effort to obtain corroboration and, in doing so, had uncovered evidence that threw genuine doubt as to the veracity of the complaints. Crown Advocate Baker's detailed Advice demonstrates that he gave proper care to the decisions that he had to reach in each case.

WN264

11.142 We set out, in Chapter 10 (paragraph 10.150) a summary of the Police investigations into allegations made by WN195 against WN264. The decision taken during the initial investigation in 2004 was that there should be no prosecution because of the absence of corroboration. John Edmonds surmised when reviewing the file in 2009, prosecutors in 2004 were wrongly applying too strict a test in respect of the need for corroboration; it would have been open to prosecutors to proceed in the absence of corroboration,

[106] WD004518
[107] WD007970/4–9

although the judge would have had to warn the jury of the risk of convicting on uncorroborated evidence. Support for the view that too strict a test was being applied can be found in the memorandum of Laurence O'Donnell dated 24 September 2004. Laurence O'Donnell, a Force Legal Adviser, wrote:

> *""I note that there are no other victims identified as a consequence of the police investigation and thus, at present, the prosecution would proceed with only one victim. The practice locally is for such prosecutions not to be proceeded with and I am of the view that, should the matter be charged, the magistrate would discharge at an old-style committal."*[108]

A handwritten note on the memorandum recorded that the AG had reviewed the file, and had also concluded that in the absence of another complainant there could be no prosecution. The note recorded that the matter would be considered again if another victim came forward.

We recognise that there would have been difficulties in any prosecution. WN195's account did not tally precisely with the records that the Police had managed to locate. However, he was apparently a credible witness. The lawyers do not seem to have considered the likelihood of a prosecution succeeding in reliance on WN195 if a corroboration warning were given.

We believe it likely that the wrong test was applied. However, we accept that the decision not to prosecute was taken in good faith. We cannot say what decision would have been made had the correct test been applied.

We note that, during the course of Operation Rectangle, the correct test was applied and the decision still made not to prosecute. We regard that decision as having been professionally made and properly; the evidential difficulties meant that it was a decision in which different lawyers might reasonably come to different views.

<u>Kevin Parr-Burman</u>

11.143 Kevin Parr-Burman was the Manager at Heathfield when he was alleged to have assaulted a child in his care by grabbing the child, who did not want go

[108] WD007441/4

to school, and frog-marching him out to the waiting car. The incident was witnessed by other staff. This was not an Operation Rectangle case.

11.144 The Force Legal Adviser, Robin Morris, advised that both the evidential and public interest tests were met, and that prosecution should follow. He noted that it was regrettable that this one incident would almost certainly lead to the end of Kevin Parr-Burman's 30-year career working with children.[109]

11.145 Because of Kevin Parr-Burman's seniority within Children's Services, Robin Morris referred the case to the AG, who asked John Edmonds for further advice. He disagreed with Robin Morris, saying that any sensible court would regard criminal proceedings as wholly inappropriate and that, while Kevin Parr-Burman's conduct might amount to assault, it was the sort of incident *"replayed in households all over the world on a daily basis without there being any serious thought of a recourse to the criminal courts".* He recognised that there were differences from the normal family situation, in that the victim was particularly vulnerable and Kevin Parr-Burman was someone in a position of trust who should have known better. Nevertheless, he considered that the matter should be resolved through internal disciplinary procedures. Further, he identified some evidential difficulties in that the staff member who witnessed the incident was a participant in some of it, and the child did not recollect the one aspect of the incident – being grabbed by the back of the T-shirt and pulled down the stairs – which was the most obvious assault. He therefore advised that there was not, in his view, a realistic prospect of conviction.[110]

11.146 The AG agreed with John Edmonds' view.[111] While John Edmonds had considered that the evidential test was not met, William Bailhache QC told the Inquiry that he had taken a broader view. He did not recall the case but, from looking at the memorandum that he sent to Robin Morris, he had clearly taken into account John Edmonds' observation that the incident, even if an

[109] WD006849/10–1
[110] WD006849/7
[111] WD006849/3–4

assault, was similar to many daily household incidents which were not prosecuted.[112]

11.147 We consider that the decision not to prosecute was professionally taken. The case was scrutinised conscientiously by all three lawyers involved. The difference in their views reflects the difficulty in cases of this sort of reaching a decision that is clearly "right"; a number of lawyers, acting entirely properly, may come to different conclusions.

WN819

11.148 WN819 was another member of staff at Heathfield, accused of a physical assault on a child in his care, stated to have taken place in January 2009. This again was not a Rectangle case. WN819 had intervened when the child, who was 15 years old, was misbehaving. A member of staff and the child said that WN819 had grabbed the child's neck and swept his feet from under him, causing the child to fall. WN819 admitted placing his hands around the child's throat, and said that he had been feeling unwell and had "snapped".

11.149 Sarah O'Donnell, a Force Legal Adviser, considered that the evidential test was met, but that the public interest test was not. She took into account the fact that a social worker had said that prosecution would not be in the best interest of the child, and also the fact that internal disciplinary proceedings were to take place.[113]

11.150 The AG was consulted. He considered that it was difficult to take an evidential decision in the absence of witness statements but accepted that Sarah O'Donnell's note indicated that the evidential test had been passed.

11.151 He continued:

> *"There is a slightly disquieting feel about this, particularly in the light of the fact that [819]'s superior[114] has also had a complaint made against him last year."*

[112] Day 128/79–80
[113] WD007918/4–6
[114] Kevin Parr-Burman

11.152 He noted that Sarah O'Donnell had been very much influenced by the view of the social worker and asked for more details of her account. In particular, he wanted to know whether she had stated in writing that the child would be adversely affected by having to appear in court as a witness. He went on:

> *"This has slightly the hallmarks of what may later be described as a cover up. It may be a perfectly good decision. The problem is that as at present, I do not think we have enough information to be able to tell the difference."*

11.153 He asked to see the entire file.[115]

11.154 In his oral evidence to this Inquiry, William Bailhache QC was asked whether the reference to a "cover-up" was a reference to a cover-up within Heathfield. He said that it was not; it reflected a consciousness of the allegations of cover-up made against the LOD in the course of Operation Rectangle.

11.155 In the end, in March 2010, the decision not to prosecute was taken. By this time, Timothy le Cocq QC was AG. The decision was taken with the authority of John Edmonds; the correspondence indicates that the Minister was to be informed.[116]

11.156 William Bailhache QC told the Inquiry that it was his function, as AG, to consider whether to prosecute; it was not for him to be concerned that allegations had been made against two members of staff at a children's home within a short time. If something came up which was not [in itself] a criminal matter but which needed attention, the right course was for the AG to notify the relevant Minister or Committee. William Bailhache said that his predecessor had reported the Victoria College situation, and that that report had led to the commissioning of the Sharp Report. It also appeared that, in the present case, Timothy le Cocq had informed the Minister.[117]

11.157 We conclude that the decision not to prosecute was professionally taken. The correspondence indicates that those involved considered the evidential sufficiency in some detail, and gave very careful thought to the public

[115] WD007918/7–8
[116] WD007918/12
[117] Day 128/87–8

interest test. There was a lengthy debate between John Edmonds and Sarah O'Donnell on the question of whether the decision not to prosecute was truly taken on the basis that the evidential test was not met, or whether it was a public interest decision. While that debate did not affect the ultimate conclusion, it does, in the Panel's view, provide us with a degree of insight into the care with which these decisions were being taken.

WN820

11.158 This 2006 case concerned an allegation of gross indecency made against another member of staff at Heathfield. The suspect gave a "no comment" interview. The police view was that prosecution should not proceed because of the absence of corroboration.[118]

11.159 Laurence O'Donnell, Force Legal Adviser, concurred with that view. In a brief memorandum, he advised that the evidential test was not met and that there was no realistic prospect of conviction.[119]

11.160 We consider that this decision was professionally taken. We recognise the difficulties faced by any prosecutor in this situation. The Police had tried but been unable to obtain evidence from another resident to whom the complainant had made her first complaint. We note that, again, neither Police nor lawyer considered expressly whether the prosecution could rely on its one witness, even with a corroboration warning. Because the documents are so brief, we cannot say for certain that the wrong test was applied, nor (if it was) can we say that the decision would definitely have been different had the correct test been used. This is an area in which different prosecutors could legitimately reach different views.

The law in respect of corroboration

11.161 All the officers investigating offences against children, and all those involved in prosecuting decisions, of course had to apply the law then in force. The law of corroboration has developed significantly in Jersey over the last 20

[118] WD006876/8
[119] WD007860

years. We believe that those developments have had an impact on prosecuting decisions.

11.162 In April 1991, Anton Skinner, the Children's Officer, wrote to the then Bailiff, requesting an urgent review of the law, which then required there to be corroboration of the evidence of a child under 14 before a defendant could be convicted on that evidence. He stated:

> *"urgency derives centrally from an inability to progress legally towards criminal prosecution in an increasing number of cases where there has been no doubt in the minds of investigating officers had grave offences against children have occurred. However, due to the present restrictions surrounding the rules of evidence as they affect children, and the circumstances under which children must give evidence, there has been no possibility of considering prosecution for these very serious offences …*
>
> *… I am also aware through the work of the Child Protection Team that, regrettably, the law as it currently stands does not appear to be able to protect the interests of children in the matter of child abuse, and most particularly, child sexual abuse. I therefore hope that this is a matter which can be addressed within the near future".*

11.163 In September 1991, a working party chaired by Sir Philip Bailhache, the then AG, was set up to address, among other matters, the law on corroboration. It produced its first report in March 1993 and recommended a change in the law. The Education Committee accepted the working party's recommendations and in 1993 passed the matter to the Legislation Committee.[120]

11.164 In 1997, the law was changed so that there was no longer a bar to prosecution in which the evidence of a child was uncorroborated. However, a judge was still required to give a warning to the jury of the dangers of relying on the uncorroborated evidence of children or complainants in sexual offence cases.

11.165 Barry Faudemer recalled that, during the 1990s, case law on similar fact evidence developed, and there were fewer restrictions on its use and it became admitted in more cases.[121]

[120] Day 125/57–58

[121] Day 113/58

11.166 This is not a matter that we have investigated. However, assuming Barry Faudemer to be correct, then corroboration of the evidence of a child witness could from the 1990s onwards have been more readily obtained through the admission of evidence that, for example, the defendant had acted in a similar way on an occasion other than the one in respect of which he was being prosecuted.

11.167 Emma Coxshall thought that there had been many investigations which had not progressed to court because of a lack of corroboration, and described the corroboration issue as "*extremely frustrating*".[122]

11.168 Robert Bonney's evidence was that *"in sexual cases corroboration, if not mandatory required, is always required in practice and it was a very significant hurdle to overcome"*.[123]

11.169 On 21 April 2008, DI Alison Fossey wrote in an email to a senior police officer Shaun du Val:

> *"Laurence [O'Donnell, lawyer within the Law Officers' Department] was of the view, as I, that a lot of cases were not proceeded with in the past due to working procedures between the police and FLA. Many files were not even referred for legal advice and were written off by the DS/DI at that time and also the corroboration rule prevented many cases being proceeded with. A major change in the law is required and we were successful in our law drafting bid for a new Sexual Offences Law this year …"*[124]

11.170 On 14 July 2009, John Edmonds, Director of the Criminal Division of the LOD, wrote in an email to the AG, William Bailhache QC:

> *" … the Legal Advisers over a period of many years have effectively been applying a test of mandatory corroboration rather than properly evaluating whether an uncorroborated victim would nonetheless be regarded as a witness of truth. I fear that Ian Christmas' involvement both as a Legal Adviser and Magistrate set the tone for much of this practice … ".*[125]

11.171 John Edmonds explained how he had come to that view:

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[122] WS000639/12–13/51 and 53

[123] Day 114/118/20–22

[124] WD007895: in his oral evidence to the Inquiry, Robert Bonney said that he had never written off a case without consultation with the Force Legal Advisers [Day 114/119–120]

[125] WD0009000/432

> *"I had seen a number of files where the way in which advice was phrased -- and I put it that way because one can't discount that it's clumsy use of words within the advices, but the advice would read along the lines of 'X says this, there is no corroboration, therefore in my view there's insufficient evidence to prosecute' -- I'm putting it briefly, but paraphrasing. And that made me wonder whether the step that -- or the stage in the thought process that should be taking place where one has an allegation in respect of which there is no supporting evidence, the next stage in that is 'Well, notwithstanding there is no supporting evidence, is what is said true? What are the reasons why this individual is giving this account?' One has to start off from a position of why would this individual be making it up and I just wasn't always clear that that stage -- or at least it wasn't always clear from the advices at that stage of what I think is the proper thought process was taking place. Again to put that into context, the case to which this related and where Laurence O'Donnell, in 2005 was it, had said there was insufficient evidence, that same case was reviewed by Baker Platt in 2010 and 2012 and on both occasions they formed the view that there was insufficient evidence. Now, I saw the 2010 and 2012 advices and I'm satisfied that they applied the evidential test properly. So it's quite possible that this is in part a semantic issue in terms of the way advices are being written ...*
>
> *I had seen several advices where in particular he [Ian Christmas] had -- in the way that they were phrased, the absence of corroboration was the sole reason why prosecution wasn't taken. The stage of 'nonetheless is this a witness of truth', that stage hadn't obviously been applied from what was contained within the advice."*[126]

However, in respect of Operation Rectangle decisions, John Edmonds said:

> *" … there isn't a single case where in my assessment the fact that there was going to be a mandatory corroboration warning tipped the balance between prosecuting and not prosecuting".*[127]

11.172 The Inquiry attempted to locate Ian Christmas and obtain his evidence. It was unsuccessful in doing so.

11.173 Bridget Shaw gave the following evidence:

> *"38) We faced a significant issue at this time [i.e. from 1998] in relation to corroboration. The term 'corroboration' has a specific legal definition. It is evidenced from a source independent of the complainant that supports the complaint in a material particular. The rules were complex but the position was that in any trial involving the evidence of a child or in a sexual case where the evidence of a complainant was adduced,*

[126] Day 126/127–9
[127] Day 126/128

the jury had to be warned that it was dangerous to convict on the uncorroborated evidence of that child or that complainant."

11.174 This was formerly the position under English law. The requirement for the corroboration of the evidence of children was abolished in England and Wales by the *Criminal Justice Act 1988*. The requirement for corroboration of the evidence of the complainant in sexual offences was abolished by the *Criminal Justice and Public Order Act 1994*. The corroboration rule in both respects was abolished in Jersey much later by the *Criminal Justice (Miscellaneous Provisions) (No.3) Law 2012*.

11.175 Bridget Shaw continued:

"40) The effect that a corroboration warning could have on a jury was an important consideration for a lawyer in determining whether there was a realistic prospect of conviction. If the complaint was not supported by any other evidence or was supported by weak circumstantial evidence then the compulsory warning to the jury was more likely to lead to an acquittal; that would have bearing on whether the evidential test was met.

41) The corroboration rule was never a bar to prosecution. Legal Advisers could advise that a charge be brought where the uncorroborated evidence was particularly compelling. In such cases there might be strong supporting evidence that fell short of the technical requirements of corroborative evidence. Nevertheless the warning would still have to be given and the continuing application of the rule was therefore a matter of concern.

42) We do not know how individual juries come to their decisions and I cannot state that in any particular case a jury would have decided differently had a corroboration warning not been given.

43) I cannot say whether the corroboration rule had an effect on the number of cases being referred to the Legal Adviser's office by the SOJP and Honorary Police: that is a question for them.

44) Although the corroboration rule had an impact, I built a good relationship with the police and there was an increase in the number of cases referred to the Legal Adviser's office. Again, without more information I cannot comment on the cause of the increase or point to when it began. Nevertheless I can say that advising on cases of suspected child abuse became an important part of my role as a Legal Advisor. I know that Detective Inspector Fossey encouraged her officers to seek advice from the Legal Advisers at an early stage."

11.176 When asked why it took so long to change the law on corroboration, Bridget Shaw said: *"At that time there was no clear route through which the matter*

could be raised. Jersey does not have a Ministry of Justice. Matters involving the courts have sometimes been sponsored by the Home Affairs Department and sometimes, I believe, by the Attorney General. However, the Attorney General is not in a position to set criminal justice policy."[128]

11.177 On 16 October 2008, the Council of Ministers considered a change to the law on corroboration. The majority of Ministers decided that further advice was needed and referred the issue to the Law Commission. The AG William Bailhache QC was in favour of abolishing the corroboration requirement.[129] The Law Commission reported in May 2009 but it was not until 2012 that the law was changed.

11.178 Sir Philip Bailhache said that, in his view, the delay in changing the law on corroboration was not due to "*the absence of political will*", but "*incompetence, probably".*[130]

11.179 We conclude that the failure to amend the law on corroboration, coupled with failings by Ian Christmas and others in the application of the existing law, did contribute to decisions not to prosecute before Operation Rectangle. We accept, however, the evidence of John Edmonds that, during Operation Rectangle, the law was correctly applied and that the fact that a mandatory corroboration warning was going to be given did not "*tip the balance"* between a decision to prosecute and one not to prosecute. It is, of course, impossible to say whether anyone was acquitted who would have been convicted had there been no mandatory corroboration warning.

11.180 The Panel cannot accept that the failure to act to change the law, on a matter vital to securing justice for children and victims of sexual offences and in the light of a clear lead from the UK Parliament, can be explained as incompetence. We are satisfied that the failure to act reflected the lack of importance accorded to this issue by the States.

[128] WS000691/7–8/all
[129] Day 124/28
[130] Day 129

11.181 While the failure to act is regrettable, there are no implications for the future safety of children now that the corroboration warning rule has been abolished.

The Report of the Independent Jersey Care Inquiry 2017

Chaired by Frances Oldham QC

Volume 3: Recommendations and Appendices

Presented to the States of Jersey

on 3 July 2017

by the

Independent Jersey Care Inquiry

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CHAPTER 12

From Findings to Recommendations

Introduction

12.1 The Inquiry makes recommendations in order to:

- identify any remedial action required to keep children in Jersey safe;
- ensure that the failings of past and their consequences are not repeated;
- promote a safe, effective system of care where children thrive and fulfil their potential.

12.2 The Panel recognises that its recommendations must:

- improve standards, performance and effectiveness;
- work in Jersey;
- build on the strengths of the community;
- be achievable within the resources of the island;
- enable Jersey to find solutions rather than create additional burdens;
- draw on the significant contributions to this Inquiry of Jersey citizens, stakeholders and agencies.

12.3 In approaching its task of making recommendations, the Inquiry had regard to:

- the current state of services for children in Jersey;
- the underlying causes of past failings;
- the lessons to be learned from past failings;
- Jersey's response to previous child care reports and reviews;
- the experience of other inquiries and research on the implementation of recommendations.

12.4 Our analysis in this chapter, and our recommendations in Chapter 13, fulfil the Inquiry's Terms of Reference 14 and 15, which require us to:

> *"Set out what lessons can be learned for the current system of residential and foster care services in Jersey and for third party providers of services for children and young people in the Island"*;

and

> *"Report on any other issues arising during the Inquiry considered to be relevant to the past safety of children in residential or foster care and other establishments run by the States, and whether these issues affect the safety of children in the future."*

The current state of services for children in Jersey

12.5 Our goals in framing recommendations are to keep children in Jersey safe and to give children in the care of the States of Jersey the best life chances. In fulfilling our Terms of Reference, we have described and analysed events since 1945, including the impact that failures in child care services have had on the lives of many children in Jersey – in some cases affecting them, their relationships and families throughout adulthood. The Panel has identified 10 failings underlying the findings that it has made. These failings allowed abusive regimes and practices to persist and flourish in the care system for many decades. These are listed in Table 12.1 and discussed more fully at paragraph 12.35 below.

These are not exclusively historic failings. Evidence, including recent serious case reviews (SCRs), has indicated that significant shortcomings persist in some areas of Jersey's services for children. We learned that, even during the period of the Inquiry hearings (2014–2016), major deficiencies were apparent in these services. Despite investment, efforts to respond to earlier reports, and repeated failings having been identified in SCRs, at the conclusion of the Inquiry's hearings, aspects of Jersey's services for children remained not fully fit for purpose.

Table 12.1: Failings in Jersey's child care services, 1945–2014

Jersey's child care services were characterised by failures to:

- value children in the care system;
- adopt an adequate legislative framework;
- keep pace with advances in the developed world;
- achieve positive, measurable outcomes for children;
- establish a culture of openness and transparency;
- mitigate the negative effects of small island culture;
- make sufficient investment in staff development;
- promote the recruitment and retention of staff;
- fulfil corporate parenting responsibilities;
- tackle a silo mentality among departments.

12.6 Foster carers perform an invaluable role: they see, daily, how States of Jersey services impact on the children they care for, and they experience how professionals operate. They told us, during the Phase 3 consultation in 2016:

> *"The service is failing our children, leaves them very vulnerable and has not learned any lessons whatsoever no matter how many SCRs have occurred";*

and

> *"I would never stand for the service for my birth child that I have seen for my foster child."*

12.7 Interim senior managers in Children's Services contributed to Phase 3 of the Inquiry and described how, as late as 2014, they found:

> *" … the residential sector was very poorly managed … rather chaotic staffing arrangements";* and

> *" … very little evidence that that robustness that is required in order to ensure that safe human beings look after our most vulnerable children was at a level which was necessary".*

12.8 They discovered that there were *"not enough social workers"*, *"no standards"* and *"no management standards"*. Residential staff directly caring for children *"had had no training for seven years prior to us coming"* and *"no proper supervision"*. Furthermore, the management style within the residential sector was *"not conducive to keeping children safe"*. There was an absence of governance and management: *"very little procedure, very little management"*. They found that children remained at risk in the community because care orders were being used inappropriately, or not being used at all. In an independent audit of assessments of children's needs, only three out of 40 assessments undertaken by social workers were found to be adequate. Vulnerable children and their families were still being failed by the system that was meant to protect them.

12.9 As these senior managers set about a programme of improving the quality of practice and the experience of young people in the care system, they described encountering strong resistance to change in parts of the staff group and a worrying lack of insight, professionalism and accountability among some staff; they described people who would *"storm out, slam doors"* when asked basic questions about what they were doing in a case or how they were identifying a child's needs.

12.10 Notwithstanding all the effort that they have put in over the last two years, as late as March 2016, the interim managers had grave concerns about some of the staff employed in Children's Services. They were "*still not convinced that some of the people are of the right calibre"* and "*still have a number of question marks around a significant number of staff*". The model of residential child care that they encountered in Jersey was described by Jo Olsson, a former interim Director of Children's Services in Jersey, as "*containment and behaviour management*". These managers were describing, in 2016, approaches to residential care and offending behaviour that have persisted for decades in Jersey, since the days of the Jersey Home for Boys (JHFB), the Jersey Home for Girls (JHFG) and Sacré Coeur. According to Jo Olsson, as

late as 2016, residential child care in Jersey still needed to be transformed into:

> *"a more holistic approach that tried to create the therapeutic environments and relationships that enabled children to recover from the adverse experiences they have had".*

12.11 These accounts are supported by the "*pretty devastating set of findings"* of a review of child care services undertaken in 2015 by former English Ofsted inspector Mary Varley. The Inquiry has seen this review, and it was discussed in evidence with Jo Olsson.[1] The Varley review, although adopting a process-focused approach, did highlight some progress in some areas of residential care, following work undertaken by Jo Olsson and her colleagues in the preceding months. Mary Varley found that, across the residential establishments that she looked at, standards were *"mostly met"* and there was a mix of *"good practice and some aspects of inadequate practice"*.

12.12 Across Children's Services generally, however, Mary Varley found widespread inadequate practice, poor assessments, a lack of focus on the child in the management of cases and a weak Independent Reviewing Officer (IRO) service incapable of driving forward improvements. Because of the nature of our Terms of Reference, the bulk of our report is focused on care provided to children in residential and foster care and has not looked more broadly at the child protection perspective. However, we consider it important to understand the position in the recent past and at present in order to assist us in making recommendations for the future and to inform our assessment of children's services more widely.

12.13 As late as 2014, Jo Olsson found a culture in Children's Services that was "*hierarchical, paternalistic and patriarchal*". It was "*quite a man's world*" where senior managers did not know what they were supposed to be doing[2] and were engaged in fruitless activity because:

> *"sometimes what happens in that circumstance is people just do things anyway because to admit you don't actually know what you are doing is just too difficult";*

[1] Day 138/188/7
[2] Day 138/159/20

and

> *"*[senior managers] *didn't know they were so far off what would be mainstream good practice".*

12.14 Jo Olsson described a Children's Services department that had deteriorated to such an extent that it would take a significant time to turn around. She explained concerns brought to her by States of Jersey Police (SOJP) officers about a reluctance by Children's Services to engage with some cases raised by the SOJP, and poor practice in children's homes that was observed by SOJP officers. The Panel noted the marked contrast, by 2014, between a proactive, child-centred response to looked after children by SOJP, which has learned from the accounts of victims in Operation Rectangle, and a residential child care sector that had not. Despite all the experience and lessons from the widely publicised cases emerging in Operation Rectangle, Jo Olsson concluded that (as of 2015) "*the quality and standard of* [social work] *practice in Jersey left children very, very vulnerable*".[3]

12.15 We were interested to hear Jo Olsson's views on why failure to learn lessons and move forward persisted in Jersey's Children's Services. In her view, a key factor was the "*moribund*" senior management, which had come about because of "*too many internal promotions over too long a period*".[4] A similar issue was highlighted by the States of Jersey in its closing submissions,[5] describing a reluctance by staff in child care services to engage in robust professional challenge and supervision because of existing social relationships, despite this issue having been identified as a concern in successive SCRs. Jo Olsson described an unwillingness by service managers and by the States of Jersey administration to address poor performance because of the potential "*dramatic and draconian*" effects of dismissing someone from their role in a state where residency qualifications and housing eligibility can be closely linked to employment status. Termination of employment can, in certain cases, trigger loss of the worker's home and of their, and their family's, right to remain on the island.

[3] Day 138/182/5
[4] Day 138/161/18
[5] Day 145/35/2

12.16 The Panel heard other evidence suggesting reluctance in States of Jersey departments to tackle performance issues for fear of the wider consequences or because of the strong interlinkage of social and professional relationships. The consequence of this mentality, it seems to us, is that Jersey has at times prioritised the welfare of government employees over the needs of children, by promoting staff out of local loyalties or allowing unsuitable or incompetent staff to remain in post rather than risk jeopardising their standing, residency or housing status. That such attitudes remain, nearly a quarter of a century after the debacle of the initial response to complaints about Jane Maguire, as described by the Jersey Care Leavers' Association (JCLA) in their closing submission,[6] is a matter of grave concern.

12.17 We concur with Jo Olsson's view that this issue arises from a failure to grasp, at many levels – politicians, senior managers and practitioners – that the first priority of States of Jersey officials and officers is to protect the island's children, on whom its future depends.

12.18 The Panel considered carefully, and has given prominence to, the evidence of Jo Olsson on the current state of child care services in Jersey, for four reasons. First, she is an experienced practitioner and manager of social work services, with a track record of transforming underperforming services. Secondly, she provided an outsider's view, having come to the island to undertake a particular role and with no agenda of seeking advancement, residency or later employment in Jersey. Thirdly, her observations are supported by the evidence and contributions of service users, other professionals and organisations in Jersey. Fourthly, and most significantly, her evidence contrasts markedly with the evidence of Anton Skinner, Richard Jouault and others on the performance of Children's Services in the period from the 1990s to the commencement of Inquiry hearings. While these witnesses described some challenges and issues within services for children, there was no suggestion in their evidence of the depth of dysfunctionality, poor quality of management and absence of basic social work skills that subsequently became apparent to the Panel through the evidence of the

[6] Day 146/151/2

SCRs and of some of the interim and current managers in post from 2014 onwards.

12.19 Had the evidence of Anton Skinner and Richard Jouault not been balanced by the evidence of Jo Olsson and others, and by many Phase 3 contributors, including care-experienced young people, the Inquiry would have been left with a very different understanding of the current condition of child care services in Jersey.

12.20 It is our view that the discrepancy between the actual performance and quality of Jersey's Children's Services and that claimed by some of its long-standing managers does not arise from an attempt to mislead the Panel or to cover up failing practice. More seriously, it derives from lack of insight, knowledge and skills related to good social work practice among senior staff – a situation characterised by several people in Jersey as "*not knowing what good looks like*".[7] For too long, in Jersey, too few people have understood "*what good looks like"* in child care; as a result, services have failed children, some of whom have suffered the consequences of unmet need and unsatisfactory care well into adulthood, and continue to suffer.

12.21 The balance of the evidence that we have seen indicates that, despite effort, investment, reviews, SCRs, reports and recommendations presented to the States of Jersey over many years, there was still not a consistently safe and effective child care service in the island by the time the Inquiry concluded its hearings in 2016. Jo Olsson told the Inquiry:

> *"I did not leave the island* [August 2015] *believing that children were safe and I still have great concerns about their safety."*

12.22 Her concerns were echoed by James Clarke, an Interim Manager, who said:

> *"You would not believe how poor …* [the standard of social work practice is] *… it is almost like trying to create a social work system on an island that has never seen social work."*[8]

12.23 The Panel therefore has to approach its recommendations from the standpoint that, despite Julia Wise-St Leger's perception of a gradual

[7] E.g. Day 143/64, Day 144/53, WS000710/32
[8] Day 143/82

emergence of what she called "*the green shoots"* of recovery*,* serious deficiencies remain in social work services, systems and practice that may leave children at risk or cause them to experience sub-standard care. Our concerns were heightened by learning of the recent departure (in October 2016) of the fifth Director of Children's Services in five years, after only a few months of employment.

12.24 We are gravely concerned by the additional instability that her departure creates in a department where concerns already exist over its fitness for purpose and its capacity to identify, protect and adequately care for vulnerable children in Jersey. In the light of all the evidence that it has heard, the Panel considers that children may still be still at risk in Jersey and that children in the care system are not always receiving the kind or quality of care and support that they need.

12.25 The outlook, however, is not entirely bleak. As part of its Phase 3 work, the Panel met with many people working in Jersey with vulnerable children and families. They included service providers, public-sector staff, foster carers and volunteers. The Panel also met families and talked with children living in residential and foster care. The Panel was impressed by the range of the work and dedication of staff and volunteers in many agencies, often, like the many groups based at The Bridge,[9] providing crucial support and filling essential gaps in provision, while constantly struggling to fundraise. The Panel heard of innovative models of care being used at Les Amis, a charitable organisation providing residential and respite services for people with learning disabilities; it also learned about and met staff from the Multi-Agency Safeguarding Hub (MASH) unit, which aims to ensure a thorough and speedy response to all child protection referrals. The Panel heard from health visitors about the aspirations they have for the vital service that they provide to women and their young children, and was impressed by their vision and dedication. It met with Child and Adolescent Mental Health Services (CAMHS) and recognised the commitment of that service to supporting children notwithstanding the

[9] See, e.g., https://www.gov.je/Caring/Organisations/Pages/Parentingsupportservices.aspx

challenges of enormous demands, limited resources and unsatisfactory and poorly maintained premises.

12.26 Time and again, the Panel encountered or heard of the enormous resources of goodwill and generosity in the island, and it saw many examples of how these are being harnessed to develop and support young people and provide opportunities for disadvantaged groups by people with a passionate commitment to the island's children. The creation of the JCLA, its ongoing work of supporting people who have experienced the island's care system and the support that it has received from the States of Jersey are examples.

12.27 The Panel also heard from professionals, civil servants and politicians about Jersey's ambitious "1001 Critical Days" initiative, which affirms the importance of loving, nurturing early-life experiences and seeks to ensure that every child in the island has the best start in life. The commitment of the States and the participation of senior Ministers and civil servants in the taskforce taking it forward are encouraging evidence of political will to confront and resolve some of Jersey's long-standing social needs. We are worried, however, that no additional funding has yet been made available for this initiative, which has the potential to transform the life experiences of vulnerable children in Jersey and impact positively on social welfare for decades to come. The Panel would be concerned if this initiative were to falter through lack of investment. It is important, also, that this work in Jersey is connected to, contributes to and learns from successful developments and initiatives internationally, such as the Parent Infant Partnership in the UK or Attachment Parenting International.

12.28 Politicians told the Panel of their determination to see the States of Jersey fulfil its responsibilities towards the children to whom it is "corporate parent", in the same way that they do for their own children. Senator Green said:

> *"For me it is very simple. I would not want anything for any other person's child, whether looked-after or supporting them in looking after their own child, that is not good enough for my own."*[10]

[10] Day 144/54

12.29 The Chief Minister set out the importance of ensuring that all States members shared this understanding of corporate parenting responsibilities:

> *"If corporate parent is about wanting to ensure that children are treated in the same way that our own children are treated that takes it in my mind to a whole new different level about how we see children. … Do we as States members see the same duty of care* [as to our own children] *to the children that we are the* [corporate] *parents of? And the answer has got to be currently today we don't. We have got to find a way of making sure that we do."*[11]

12.30 This approach is the crucial foundation for a safe and effective child care service in Jersey, and we are encouraged by the aspirations of senior politicians in this regard. Jersey also has in its community many individuals and organisations passionate about improving the quality of life experiences of vulnerable children, including foster carers, youth organisations and volunteer visitors. The dedication and experience of these groups and individuals must be harnessed and used in driving forward and sustaining change in services for young people – not least in informing policy and helping to hold politicians and professionals to account.

12.31 The Panel also found in Jersey some impressive examples of effective leadership and of relevant expertise that can be drawn on to improve underperforming areas of children's services. The Probation Service has recruited and developed a stable staff group, benefiting from regular professional challenge and supervision. The service has international links, enabling staff to be exposed to and draw on good practice from other jurisdictions and to assist other island communities. The SOJP's Public Protection Unit (PPU), under the leadership of now-DCI Alison Fossey, has kept pace with international developments and approaches to crimes against children and has been proactive in adopting learning from Operation Rectangle and in its work to protect children. Les Amis has established a tradition of staff supervision and development.

12.32 We saw in these organisations that good leadership was evident, characterised by setting high standards in keeping with modern practice,

[11] Day 144/156

emphasis on developing staff, effective supervision and holding staff accountable for their performance.

12.33 We also heard evidence from many witnesses of the warm, nurturing environment previously operating at Brig-y-Don Home (BYD) under the management of Margaret Holley. The consistently compassionate care described by many former residents contrasted starkly with the harsh and abusive regimes operating in other Jersey homes in the same period. During Margaret Holley's tenure at BYD, staff turnover was low, and staff were encouraged to develop new skills and pioneer methods of working with children, such as shared care, that would enhance their life experiences. Frustratingly, no opportunity was taken to learn from BYD or to disseminate its good practices among other homes. Over many decades, each child care residential institution in Jersey operated in isolation, including all the homes established or taken over by the States of Jersey.

12.34 The Panel believes that this silo mentality must be broken down – not only among care homes, but also across all States departments, so that exceptional practice in one area is acknowledged and promulgated everywhere, including with partners in other sectors. There should be no place in the States of Jersey's operations for managers who place the protection of their "territory" ahead of willingness to work in a corporate manner, open to learning and adopting good practice from colleagues. In this sphere, it is crucial that a strong example of co-operative, cross-departmental, resource-sharing collegiate working is set by the Council of Ministers.

Understanding and addressing the causes of systemic failings

12.35 The Panel's review of the evidence of hundreds of witnesses and in excess of a million documents have informed the findings set out in Chapters 2–11 in relation to the care of children in Jersey from 1945 onwards. We have identified **10 underlying and recurring systemic failings** that created or sustained the conditions in which abuse and neglect of children in the care of the States occurred.

12.36 Understanding the causes of these failings is crucial to avoiding the mistakes of the past and responding to the problems of the present. Each failing is considered in detail below, followed by a summary of lessons to be learned.

12.37 We believe that only by addressing these systemic failings, and considering the lessons to be learned from them, can Jersey's care for children be transformed, made fit for purpose and enable children in the care of the state to be kept safe and thrive.

12.38 With this in mind, we have formulated our recommendations (Chapter 13) to address these systemic failings. **The Panel firmly believes that focusing on and implementing a small number of recommendations to address the underlying, persistent causes of child care service failings will be more effective than pursuing an extensive list of recommendations that deal only with the symptoms of the root problems.**

12.39 The 10 fundamental failings in the Jersey child care system are:

- Failure to **value children in the care system**, listen to them, ensure that they are nurtured, and give them adequate opportunities to flourish in childhood and beyond.
- Failure to have in place **an adequate legislative framework** that prioritises the welfare of children in need or at risk (in respect of both child welfare and youth offending).
- Failure to **keep pace with developments** in social policy, child care practice and social work standards in the developed world.
- Failure to plan and deliver services in an effective, targeted manner to **achieve positive, measurable outcomes** for children.
- Failure to **establish a culture of openness and transparency,** leading to a perception, at least, of collusion and cover-up.
- Failure to **mitigate negative effects of small island culture** and its challenges.
- Failure to **make sufficient investment** in staff development and training.

- Failure to adopt and implement policies that would **promote the recruitment and retention of staff** with essential skills in child welfare and child protection.

- Failure of the States of Jersey to understand and **fulfil corporate parenting responsibilities,** including adequate aftercare of children who have been looked after by the state.

- Failure to tackle a **silo mentality** among public-sector agencies.

12.40 **Failure to value children in the care system, listen to them and ensure that they are nurtured, and give them adequate opportunities to flourish in childhood and beyond.** The absence of effective practice in assessment of children's needs and lack of investment in securing stable, appropriate, and, where indicated, permanent care solutions (problems that were still evident as late as 2015) are indicators of the low priority that has traditionally been assigned to the needs of vulnerable children in Jersey. The long-standing failure to prioritise and invest in the recruitment, management, supervision and continuing development of staff with suitable backgrounds and skills to care for children also highlights the low value that has been, and in instances still appears to be, accorded to residential child care in Jersey.

12.41 For decades, residential establishments, including Family Group Homes (FGHs), were allowed to operate as individual fiefdoms, with no adequate professional oversight from senior children's service managers, while politicians failed to set standards or hold managers to account for their performance. Where children, and occasionally staff, expressed concerns or complaints about their treatment or the regime in their care settings, these were often minimised or ignored. The welfare, employment and employability of staff were given more priority than the wellbeing of children; staff whose approach was known to be unsuitable and staff with problems that affected their ability to care for children were tolerated by colleagues and managers while children suffered the consequences. Such attitudes could only flourish in a system that failed to prioritise the needs of children or to value them.

12.42 Nearly 30 years after the introduction of children's rights officers and complaints processes for children in UK jurisdictions, during Phase 3 of the Inquiry, young people in Jersey's care system told us that they feel that they have no effective mechanism for making representations or raising concerns, and that they are not being listened to. These young people are not looking for procedures, documents and leaflets: they want to have confidence that the people looking after them are skilled, compassionate and trained to take seriously the issues that they raise and to see them through to a resolution.

12.43 In the Inquiry's Phase 3 discussions, politicians and senior managers acknowledged that, historically, Jersey has not provided adequate educational or other opportunities for young people in its care. In earlier decades, looked after children were stigmatised and sometimes discriminated against in the educational system. While attitudes now are more enlightened, it is recognised that more investment is required to ensure that looked after children have access to all the opportunities necessary to enable them to develop their potential.

12.44 Children with emotional, psychological and mental health needs in Jersey have also been let down by a failure to modernise and resource specialist services adequately. The Inquiry heard evidence of insufficient attention being given to the emotional needs of children affected by abuse and neglect and of children with mental health needs being subjected to inappropriate institutionalised care and treatment. While the current CAMHS system appears well integrated into safeguarding systems, even today, its essential work appears to be undervalued as it struggles with heavy and increasing demands while operating from premises ill suited to the needs of children and families.

12.45 The Inquiry has heard evidence of current residential care arrangements for children in Jersey, and was concerned to note during Phase 3 that unacceptable attitudes and outdated practices are still apparent in some settings that have failed to deliver a nurturing and homely environment for young people.

12.46 **Failure to have in place an adequate legislative framework that prioritises the welfare of children in need or at risk (in respect of both child welfare and youth offending matters).** Jersey's child care legislation has lagged behind that of other jurisdictions in the UK and elsewhere in the developed world – often by decades. This has meant that whole generations of children have endured sub-standard provision and outdated attitudes. For example, while English child care was significantly overhauled in 1989 to reflect advances in research and practice, it took another 13 years before Jersey passed a modern Act (the *Children (Jersey) Law 2002*), by which time England was well on the way to enacting a new *Children Act 2004* to reflect advances, particularly in the area of assessment and management of child protection cases. As Jersey's legislative framework is most closely aligned with that of England, the Panel believes that it is appropriate to model and mirror English legislative developments, tailoring their application to Jersey's needs and taking advantage of the extensive policy and practice guidance that support English child care law.

12.47 While Jersey must adapt any English law to the special circumstances of the island, it is important that the temptation to cherry-pick elements of English law is avoided. The *Children Act 1989* in England is predicated on the principles that the state must identify and respond to both need and risk, that early strategic interventions can prevent risks to children developing or increasing and that responses by the state should be determined by the needs of the child rather than the nature of the services available.

12.48 Aspects of the 1989 English legislation that Jersey has adopted, such as the principle that the interests of the child are paramount, have not always been fully embedded in practice and decision making because of an absence of training and guidance on the application of the law in everyday practice.

12.49 The legislative basis of the Jersey Law has been further weakened by failure to adopt the key underpinning elements of the English Act in their entirety – specifically the failure to recognise in law the concept of a "child in need"[12]

[12] Section 17 of the 1989 Act states: "It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part) - (a)to safeguard and promote the welfare of children within their area who are in need; and (b)so far as is

and the state's duty towards such children – which has led to a lack of impetus in tackling the causes of deprivation and of child maltreatment, a lack of clarity about thresholds for intervention and insufficient weight being given to the rights and assessed needs of children and young people. Tony Le Sueur explained to the Inquiry:[13]

> *"My point is the concept of a child in need is not apparent in a requirement for the government to resource and look after children who are in need. We use the words but we put nothing behind it. So we have front line services, we have looked-after children funded, we have child protection funded but actually the mass at the middle which is children in need at various levels is almost not there and not supported by any sort of legislation and because the legislation is not there, the resources are not there."*

12.50 There is currently in Jersey no statutory provision in respect of preventative measures, thresholds for intervention, rights and needs of children, all supported by robust practice guidance that assists professionals (social workers, jurists, probation officers and others) in the day-to-day application of the law. The argument has been made to the Inquiry that Jersey does not have the legal resources to keep pace with developments in child care law elsewhere, not least because of a lack of policy officers and of staff to draft legislation. The Panel has noted, however, evidence suggesting that the States of Jersey has always been able to secure and devote sufficient legal resources to keep pace with developments in international financial law.[14]

12.51 Child care theory and practice will continue to advance, and child care law in Jersey will need to be continuously reviewed and updated. Developing a close affiliation with one or more English authorities and English higher learning institutions would enable Jersey to benefit from developments and expertise in that jurisdiction and to participate in initiatives that underpin new legislation, such as the recent "Putting Children First" project and the forthcoming "What Works" Centre.[15] A small central policy unit in Jersey could work with their counterparts in England to ensure that child care legislation is translated into

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consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs."

[13] Day 89/164/2

[14] E.g. Day 135/16/20

[15] Department for Education (July 2016) *"Putting children first delivering our vision for excellent children's social care"* London Department for Education (DfE)

effective policy and practice. It is also vital that the underpinning practice guidance for child care legislation, which was long absent in Jersey, is not delivered simply as an instruction manual but is supported by continuing investment in extensive and repeated training and development programmes for staff.

12.52 The Panel understands from evidence heard in Phase 3 that Jersey has considered developing close links with Scottish government departments and authorities. While we would encourage Jersey to seek good practice models and expertise throughout the world, we do not see any advantage in pursuing Scottish connections at the expense of relationships with English departments and authorities. Scotland's child care legislation differs significantly from the English law on which Jersey's law is based; youth justice legislation in Scotland is also markedly different, reflecting the operation of the Children's Hearing system. Exchanges of staff and experts between Scotland and Jersey would be more time consuming and costly than a partnership with an English south coast or Home Counties authority. In this respect, the SOJP serves as a good model: the force draws on the best of policy and practice development in policing throughout the UK and the world and has arrangements for partnership and assistance with authorities in the south of England. The Panel has visited and been briefed on the adoption by Guernsey of the Scottish Children's Hearing system, which it has been told is working well. The adoption of that system, at the instigation of the Bailiff of Guernsey, was part of a root-and-branch overhaul and transformation of that island's child care law and policy. While we recognise the advantages of the Children's Hearing approach, we do not advise this type of reformation of Jersey's child care legislation at this time, believing that the immediate priority is to ensure that current services are safe and of a high standard.

12.53 **Failure to keep pace with developments in social policy, child care practice and social work standards in the developed world**. Post-World War Two, research on the needs of children, some of which arose from the effects of war and displacement, informed legislation and social policies throughout the developed world. International co-operation and knowledge exchanges helped to improve practice and practice standards and to promote

new ways of working with children and families. Jersey, however, became increasingly disconnected from mainstream trends and thinking on child welfare in the post-War period. Attempts to adopt selective aspects of English practice development (such as FGHs) or child care legislation (such as the *Children Act 1989*) were ultimately unsuccessful because there was a limited grasp in the island of the underlying research, principles, policies and skills required to support these initiatives. There has also been a failure to recognise the pace of change and development in social care and that, as research and practice constantly evolve, so models that were once lauded may become discredited (for example, FGHs).

12.54 Additionally, although the European Convention on Human Rights (ECHR) was extended to the island in 1953, the island failed to keep pace with international initiatives in respect of common rights of children and the adoption of principles that should underpin systems of care, including juvenile justice systems. Elsewhere, the UN Declaration on the Rights of the Child 1959 laid the foundation for children being seen as individuals with rights, and stressed the importance of children being raised in loving, nurturing environments with access to good educational opportunities. The UN Convention on the Rights of the Child 1989 (UNCRC)[16] was signed and ratified in the UK within a year, but took a further quarter of a century to be adopted in Jersey. The UNCRC formalised and consolidated principles, policy and practice known 25 years ago to be in the best interests of children, including affirming children's individual rights and the necessity for children of access to assistance to secure those rights, ensuring that children's rights and interests were safeguarded in judicial systems and that children were deprived of liberty and family life for only the most serious of offences. In contrast to practice in Jersey in the late 1980s through to the late 2000s, the UNCRC, in keeping with practice throughout the developed world, requires states to adopt measures for dealing with children considered to have broken state laws *"without resorting to judicial proceedings"* and to advance approaches:

[16] See https://www.unicef.org/crc/files/Rights_overview.pdf

> *" … such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence".*[17]

12.55 The adoption of the UNCRC was considered in Jersey in 1994, but the Policy and Resources Committee was unsure of the necessity to protect children in this way.[18] Marnie Baudains said in evidence that she found it unacceptable that Jersey had been "*so dilatory in fulfilling the requirements to become a signatory"* to the UNCRC and thought it had not been done because of a focus on the juvenile employment regulations that would need to be in place. She said that politicians were "*missing the importance of it".*[19] The protracted delay in adopting the UNCRC in Jersey meant that Jersey's children were potentially denied rights and opportunities that had been available to children in 190 other countries for up to 25 years. The argument has been made that the proportion of looked after children in Jersey was not markedly higher than that in England for most of the period under review by the Inquiry: what is significant, however, is that children in Jersey were removed from their families or had residential care orders imposed for reasons or offences that elsewhere often would not have warranted state intervention or would have been dealt with by family support, a caution or a community, welfare-based approach.

12.56 For decades, Jersey has lagged behind the developed world in child care services. Jersey's service has been characterised by an absence of any planning or purposeful intervention (which meant that children languished unnecessarily in care for prolonged periods) and the use of inappropriate sanctions, such as withdrawal of home leave and family contact (which had been long known to diminish the likelihood of successful re-integration into the community) up to the early 2000s. In Jersey, there has been an ill-informed, misguided and potentially harmful approach to secure accommodation that was used routinely for children whose needs, in our view, would elsewhere have likely not met the threshold for secure detention, and without the

[17] UNCRC, Article 40b
[18] WD005212/5
[19] Day 91/156–157

thorough assessment or rigorous safeguards that were in place in other jurisdictions for the exceptional circumstances in which it was warranted.

12.57 Instead of moving consistently in step with international developments, child care in Jersey has tended to make sporadic, limited advances through the influence of a few individuals who have brought wide-ranging experience to the island and have succeeded in developing some areas of practice.

12.58 For example, in the 1960s, Patricia Thornton sought to bring new thinking and practice standards to community social work with children in the island. The magnitude of the task of modernising an entire system was not achievable by one person either then or later. Patricia Thornton's difficulties were compounded by having no line management responsibility for residential services, which were particularly isolated from mainstream social work. The problems of disconnection from common standards and practices were compounded in later decades by reliance on, and in some cases rapid promotion of, local managers with limited understanding or experience of the theory and principles that were elsewhere driving forward changes in service provision for children and families.

12.59 **Failure to plan and deliver services in an effective, targeted manner geared to achieving positive, measurable outcomes for children.** Over many decades in Jersey there was a lack of clarity about the principles that should have been underpinning child welfare policies; an absence of clarity about thresholds for state intervention in families; insufficient practice guidance for social workers and residential workers (including in residential educational establishments such as Les Chênes); and little consideration of what outcomes were needed or should be sought for children. As a result, there was often little consistency in decision making around admissions to care, inadequate assessment of children and their circumstances before removing them from their families and little, if any, matching of children's needs and institutional and other provision. Over decades, many children endured extended periods of institutional or foster care whose purpose, even

now in adulthood, remains unclear to them.[20] At a case level, there was, for decades, little evidence of a considered approach to the needs of and desired outcomes for individual children, while, at a strategic level, there was a marked absence of government initiatives to tackle the causes of social inequalities and deprivation or to promote the welfare of children.

12.60 In the youth justice system, the absence of a welfare-based approach and, until relatively recently, the lack of understanding throughout the system of the impact of early trauma on children has seen a history of punitive approaches being taken to children whose misdemeanours likely would not have reached the threshold for prosecution in other jurisdictions. During the operation of Les Chênes, some children were repeatedly remanded or sentenced to periods of residence. As set out in Table 12.2, 44 children had between four and 17 admissions to Les Chênes in their early teenage years.

Table 12.2: Les Chênes admissions

No. of admissions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
No. of children	239	58	24	11	6	6	4	5	1	0	4	0	2	3	1	0	1

12.61 Although the institution was manifestly failing to address and resolve these 44 children's difficulties or propensities, the same solution was adopted repeatedly. The system had all the hallmarks of an outdated approach geared to contain children considered a nuisance to society, rather than assessing, identifying and meeting their needs and working toward agreed outcomes. This approach persisted as late as 2014.[21] At strategic level, there was little evidence in Jersey of developing the alternatives to custody and crime diversion schemes that characterised youth justice elsewhere from the 1980s onwards. There was also a failure to provide appropriate resources and inputs to address the causes of offending and to mitigate early adverse or abusive experiences.

[20] Although we do acknowledge that well-considered decisions to take children into care can be made, which are not understood at the time by the child or their family
[21] Day 138/182/19

12.62 **Failure to establish a culture of openness and transparency, leading to a perception, at least, of collusion and cover-up.** Three key failings in this area have been evident in services for children over many years: (i) the absence of a culture that encourages the reporting of poor and abusive practice; (ii) a lack of transparency in acknowledging and investigating problems; and (iii) a tendency to protect the interests of staff – even those who appeared to have actively harmed children – over those of children.

12.63 The Inquiry heard many instances, over many years, of failures to address – or to address adequately – problems in staff conduct or performance when they came to light. A picture emerged of an organisational culture that tended to put the reputation of agencies, staff and even the island itself ahead of the interests of children. Politicians (including, importantly, those who sat on the Education Committee and/or the Health and Social Services Committee and who therefore had a direct oversight role for children in care) were at times not informed or were misled about allegations of abuse in residential settings as senior staff appeared more concerned to protect their reputations and positions than to reveal failings in management and in care. This extended even to failing to notify other jurisdictions of the existence of allegations or performance issues relating to child care staff who had left or been encouraged to leave the island. At times, efforts to protect the island's reputation and international standing, while well intentioned, have misguidedly failed to acknowledge the gravity of the island's failings in respect of its children or the egregious nature of some of the abuses perpetrated on them. Such attitudes have only increased suspicion of politicians and professionals and their motives, impacting on the social cohesion of the community.

12.64 While the public apology by the Chief Minister to children formerly in the care of the States and the instigation of the Historic Redress Scheme have gone some way to emphasise a more open and accountable approach, there is still widespread scepticism and distrust of government in Jersey. This has not been helped by an organisational culture with engrained defensive attitudes where, even now, there is a cultural reluctance in Children's Services to acknowledge shortcomings in practice and performance.

12.65 The long-standing tendencies within some States departments towards a lack of openness and towards self-protection have in some measure contributed to the deep suspicion within parts of the community that most politicians and States employees cannot be trusted and that abusive practices have been covered up.

12.66 **Failure to mitigate negative effects of small island culture and its challenges.** The Inquiry heard considerable evidence of failures to address some of the known problems of delivering services in a small island where clients, staff and politicians often have interlinked relationships. Failures have included ignoring or failing to manage conflicts of interest and prioritising the welfare of staff over the needs of children, including children in other jurisdictions to which known or suspected abusers have been encouraged to move without relevant authorities being alerted to concerns. While the benefits of a compact and closely linked community can have many advantages for service provision, such as ease of collating information from a number of sources for a comprehensive assessment, all too often, in the past, the negative aspects of a small community have dominated the operation of services – for example, where identifiable information about family circumstances and health matters were shared with politicians and committee members or where personal knowledge or beliefs about a family, rather than an independent professional assessment of need, have determined the nature of interventions by professionals. The Inquiry also heard examples of staff being appointed with more regard being paid to their local and social connections than their suitability and capability to care for children. It is important not only that States services are adept at using the advantages of operating in an island setting but also that they are characterised by a robust professionalism that promotes transparency, impartiality and openness.

12.67 **Failure to make sufficient investment in staff development and training.** Failure to invest in staff development suggests that not only children but also staff are not truly valued. The Inquiry has heard considerable evidence that, over many decades, teams of unskilled staff were left to run institutions, or to work with children with severe and enduring emotional needs, without any or adequate training or oversight.

12.68 The benefits of good-quality training are obvious. It is notable that the abusive regime at Blanche Pierre first came to light when two residential staff were given an opportunity to attend a staff development course and were exposed to different standards of practice. The approach and professionalism of Dorothy Inglis, the course leader, gave them confidence to raise their concerns about Jane and Alan Maguire's care of the children in the Group Home. Unfortunately, too few such opportunities have been available to Children's Services staff over many years.

12.69 Staff development is not achieved simply by sending large numbers of people on courses: it requires a culture of consistent, challenging, supportive supervision and effective management, including leading by example, underpinned by regular opportunities to participate in and utilise high-quality skills training. Social care training, including residential care training, is a specialist area that cannot be subsumed into wider health service training or delivered from within an existing staff group. SOJP officers working in the field of child protection have had opportunities for more than 25 years to attend UK and international specialist courses, covering areas such as communication with and interviewing children, and have been able to keep their skills up to date. By contrast, for many years, Children's Services relied heavily on occasional external contributors and inputs from local staff, including Danny Wherry, whose delivery of training was criticised in evidence heard by the Inquiry. Training for residential staff was also provided by Prison Service staff despite the unsuitability of prison-based models of care for looked after children.

12.70 In the early 2000s, the Jersey Child Protection Committee (JCPC) sought to introduce systematic child protection training, including multi-agency training. It is to the credit of their training officers that some multi-agency training initiatives were established through innovative use of the meagre resources made available to them. The long-standing failure of senior managers and politicians, however, to seek to address decades of under-investment and major skills deficits, particularly in Children's Services, has, until recently, been indicative of the lack of insight and lack of commitment to the welfare of Jersey's most vulnerable children

12.71 The findings of recent audits and internal reviews of practice in Children's Services suggests that, despite recent initiatives, much remains to be done and that further significant commitment and investment in skills and practice standards are required, as well as the provision of continuing opportunities for multi-agency training.

12.72 **Failure to adopt policies that would promote the recruitment and retention of staff with essential skills in child welfare and child protection.** Jersey has, over many years, devised and adopted policies that have made it an attractive location for "high-value residents" and for businesses who bring major investment and international financial facilities and expertise to the island. Financial incentives and expedited residency qualifications are among some of the benefits established by the States of Jersey that draw valued individuals and organisations to the island. By contrast, little effort has gone into identifying and creating the incentives that would make Jersey competitive in recruiting and retaining exceptional managers and staff to care for the island's highest-value assets: its children. Even attempts to have social work and related posts established as essential worker status have frequently floundered in cross-departmental bureaucracy because of a lack of a corporate approach to prioritising the protection and promotion of the interests of children.

12.73 Many of the failings of the past in Children's Services can be attributed to the appointment of staff, from both within and outside the island, who lacked the skills necessary for creative, informed, effective and accountable leadership. The Probation Service has demonstrated that local talent can be recruited, mentored, nurtured and developed through an extensive programme of supervision, staff development opportunities and exposure to practice in other jurisdictions. While such an approach could be devised and developed in Children's Services over the coming years, the reality is that, for the next two decades, Jersey will have to recruit social work and social care staff and managers from outside the island to manage the transformation of its services and to establish and sustain high standards of practice and performance in community and residential child care services. To attract and retain staff of the right calibre, a new approach is required to recruitment and retention, which

demonstrates the value that the island places on services for its children. At the time of the preparation of this Report, Children's Services is faced with recruiting its sixth Director of Children's Services in six years.

12.74 The indirect costs of repeated unsuccessful or short-term appointments – a loss of momentum, morale and stability, and adverse impact on interagency partnership working – are factored in alongside actual recruitment costs and the potential risks of appointing a candidate who is the strongest in the pool but not necessarily the best match for the post, make a compelling case for a complete re-think of how key staff are recruited, compensated and given inducements to commit to an agreed-term appointment (subject to satisfactory performance).

12.75 **Failure of the States of Jersey to understand and fulfil corporate parenting responsibilities, including adequate aftercare of children who have been looked after by the state.** For decades, children in Jersey have been failed by the state that took on parental responsibility for them. Children suffered because of the unsuitability of the care settings provided, the outdated and misguided care regimes that limited or prevented contact with families and the lack of monitoring of their care or planning for their interests and future. Many adults whose stories we heard had been essentially left to their own devices on reaching school leaving age; some had quickly become homeless. Others had been placed in unsatisfactory accommodation or exploitative work settings. We heard many accounts of those who had been through the care system and had been unable to build stable, fruitful lives and relationships in their adult lives.

12.76 Care-experienced adults who have managed to secure and build on relationship and employment security have generally attributed their success to the support of one or more persons who took an interest in them or cared for them in young adulthood – sometimes a foster carer, a teacher, a family member/friend or a partner. One witness also commended the strong interest and support of Patricia Thornton, who maintained personal contact long after her professional responsibilities had ceased. These adults' experiences were exceptional. The overwhelming majority of adults who had been in the care

system, and whose stories the Inquiry heard, still suffer from the effects of experiencing abusive or emotionally neglectful childhoods, their difficulties often having been compounded by being turned out, unsupported, into a world with which they were singularly ill equipped to cope. The States of Jersey, which stepped in to remove these children from situations deemed harmful or unsatisfactory, has, for decades, been an ineffectual, neglectful parent.

12.77 Much of the difficulty has stemmed from the lack of insight or interest displayed by many States members about their responsibilities as the corporate parent. While some advances have been made recently, such as the introduction of briefings for States members on their corporate parent role, these have been poorly attended. The Inquiry heard evidence from a small number of States members and Ministers, including the Chief Minister, who have a clear understanding of the States' responsibilities and who have affirmed their belief that they would wish children in the care of the state to have the same nurture and the same life chances as they would want for their own children and grandchildren. Unfortunately, this level of insight into the corporate parent duty of care does not appear to be widespread. Like all developed nations, Jersey has legislated for the aftercare of children for whom the States has had parental responsibility and has identified an age at which state support should cease. If Jersey truly seeks to provide looked after children with experience and opportunities comparable with a good family experience, there must be recognition that, while parents' relationships change as their children move into adulthood, they do not cease.

12.78 **Failure to tackle a silo mentality among and within public-sector agencies.** A lack of genuine corporate working has been evident over many decades, within the States of Jersey and between the States and some other agencies. Often, departments and institutions have been characterised by territorialism and protectiveness rather than openness to pooling resources and learning. As a result, there has been a lack of a comprehensive strategy to secure the best interests of children in the island and to tackle the causes of social disadvantage. While there is currently evidence of good partnership working between front-line practitioners, there is still little evidence of a

readiness to prioritise the needs of vulnerable children and disadvantaged families over traditional departmental roles and resources. One consequence of adherence to the silo model has been a failure within the States to learn from, disseminate and adopt good practice models across institutions, sectors and departments.

12.79 Good practice in residential care has existed in Jersey, such as the exceptional leadership of Margaret Holley at BYD; Blanche Pierre under the management of Audrey Mills; or the models pioneered at Les Amis. However, and overwhelmingly, States residential children's homes and other institutions were for many decades allowed to operate as almost autonomous entities, with models of care influenced strongly by the head of the home, who sometimes treated the institution as a personal fiefdom. Had the initiative been taken to bring practice in all establishments up to the high standards evident in the few, the experiences of many children over many years might have been entirely different.

Lessons to be learned from Jersey's past failures

12.80 There are **eight** basic lessons to be identified from the failures of the past:

- The welfare and interests of children are paramount and trump all other considerations.
- Give children a voice – and then listen to it.
- Be clear about what services are trying to do and the standards that they should attain.
- Independent scrutiny is essential.
- Stay connected.
- Investment is essential.
- Quality of leadership and professionalism are fundamental requirements.
- Openness and transparency must characterise the culture of public services.

12.81 **The interests of children, in Jersey and beyond, trump any other consideration.** *Article 2 of the Children (Jersey) Law 2002* refers to the welfare of the child being the paramount consideration. This principle now needs to be applied consistently and robustly, to be embedded in the culture of all States institutions and to be promoted throughout the island. Traditional values, operating and management practices, the needs or employment status of staff, convenience and the reputation of the island should all be secondary considerations to the interests and welfare of children. The States of Jersey members, as corporate parents, should commit to providing no less for children in the care system than they would for their own children and grandchildren through childhood and into adult life.

12.82 **Give children a voice – and then listen to it.** It is inordinately difficult for children to express concerns or raise representations effectively. Adults often profess to be listening to children, without actually hearing them. Children express their feelings and anxieties in all sorts of ways that adults and professionals miss – for example, through their behaviour. Children often test a system by raising a seemingly trivial concern – for example, about mealtimes – to see the response that they get. Looked after children have often had poor experiences of adults and are unlikely to trust any professional or volunteer who comes along to "listen" to them. All children are different, and the "listen to children" box cannot be ticked by providing one process or one set of documentation. A range of channels through which children can express their feelings and worries is required. Responsive, robust, powerful and accountable mechanisms need to be in place to deal with these matters. The most effective way of giving children confidence that they will be heard is to demonstrate that they have been listened to and that, as a result, things have changed.

12.83 **Be clear about what services are trying to do and the standards that they should attain.** Jersey needs to articulate its aspirations and the standards it seeks for the performance of staff, for children in its care and for wider services for children in the island. It needs to have clear thresholds for state intervention in families, including in respect of youth offending. All social work engagement with children and families, in the community or in care

settings, should have clear objectives based on a thorough and accurate assessment of needs, and be working towards defined outcomes, regularly monitored and evaluated. Input from families and children should be a key element of evaluation. At a strategic level, good, simple data is required to track the impact and cost-effectiveness of programmes and services. Strategic planning and policy, including improvement plans, should be rooted in children's experiences and linked to practice and outcomes – not process driven or pre-occupied by project-management tools such as Red, Amber and Green (RAG) ratings that can give the illusion of progress being achieved that, in reality, exists only on paper.

12.84 **Independent scrutiny is essential.** Regular scrutiny of child care law, policy and practice by individuals or agencies entirely independent of Jersey is essential. Independent scrutiny of implementation of the recommendations of this Inquiry is also required. These scrutiny bodies/persons must have no connection with or financial interest in Jersey, and no conflict of interest through prior or current association with Jersey institutions or personnel. It is essential that their independence is maintained by a degree of separation from the island: no-one involved in such scrutiny should be based in Jersey or employ staff from Jersey in their work. While in Jersey, persons involved in scrutiny work should avoid even the perception of conflict of interest or partiality by basing themselves in a neutral venue, wherever practicable, and should not be involved in social meetings with Jersey civil servants, politicians or agents of the States.

12.85 **Stay connected.** Jersey must ensure not only that child care and youth justice legislation, policy and practice are compliant with current standards in the developed world, and with ECHR and UNCRC principles, but also that legislation policy and practice are regularly being informed and evolving in line with research and developments. Staff must have opportunities to experience good practice in a range of settings. States members and policy makers need to be kept informed of new learning, research and models of practice in order to set a strategic direction that is tailored to the needs of Jersey. As Jersey's child care legislation is based on English child care law, the Panel believes that relationships should be developed with English academic institutions,

public-sector departments and authorities to optimise resources and opportunities for exchanges and learning. Jersey should also keep abreast of practice and social policy developments in European countries, particularly those operating at local level (in Scandinavia and the Netherlands, for example) to identify models and partnerships that might assist.

12.86 **Investment is essential.** Children are the island's most valuable asset. Every child, regardless of circumstances, should have an equal opportunity to grow up safely, to benefit from Jersey's educational provision and to thrive emotionally and physically. Every child in Jersey is key to securing the island's future, prosperity and international standing, but that will not be achieved without investment and according the island's children's services priority comparable with its financial services.

12.87 **Quality of leadership and professionalism are fundamental requirements.** Services for the most vulnerable children should not be delivered simply by whoever happens to be available. Skilled and knowledgeable professionals are required, who keep up to date in their field, who are supervised and encouraged to improve constantly and whose performance is regularly monitored. Creative, skilled, strategic leadership that is child focused and rooted in the fundamentals of good practice is essential and must be secured, even if that requires dispensing with traditional recruitment and retention policies. Providing for and responding to the needs of Jersey's vulnerable children may require the creation of special categories of work and residency licences in order to attract and retain the best available leadership and skills in the field.

12.88 **Openness and transparency must characterise the culture of public services.** Considerable distrust of the political system, the courts and children's services exists among care-experienced adults and their families and among some current users of Children's Services. In many cases, their suspicion can be traced to experiences of not being listened to or of not having explained to them reasons for certain decisions being made. In other instances, former residents of care homes have experienced the distress and dismay of seeing those responsible for abusive or unprofessional conduct go

unchallenged or unpunished, including instances when alleged abusers were allowed to leave their employment or the island with glowing or neutral references.

12.89 Many victims of abuse in the care system consider that such actions were taken in order to conceal problems in the system or to protect the reputation of individuals, departments or the island. In at least some instances, we think that they were right. At other times, the perception of cover-up stemmed from outdated attitudes of defensiveness, poor communication and an absence of a culture that valued and promoted public accountability. Sadly, many former residents of care homes in Jersey may never regain their trust in the island's government, because they were so badly failed by their corporate parent. It is imperative that future generations do not inherit this distrust of, and attendant disconnection from, the political systems and professional care services. This will be achieved only by a cultural shift throughout the States of Jersey and its services to promote greater transparency in decision making and greater openness in communication. This includes a greater readiness by politicians and professionals to admit problems, shortcomings and failures promptly and fully when they do occur, and to address them. We recognise that, in an island community, where it is not possible, as elsewhere, for public servants to remain anonymous, considerable integrity and fortitude are required publicly to admit mistakes and shortcomings. Greater openness about failures and readiness to resolve them will demonstrate, however, greater public accountability and garner the respect and trust of the community.

Jersey's response to previous child care reports and reviews

12.90 The Panel has considered how Jersey's past experience of managing recommendations about its child care services might inform its approach to this Inquiry's recommendations, in order to maximise the chances of the recommendations effecting necessary changes in legislation, policy and practice.

12.91 The Inquiry heard evidence of Jersey commissioning reports but not implementing recommendations (for example, the Clothier Report) or implementing recommendations selectively (for example, the Lambert and

Wilkinson Report) or failing to address underlying problems (for example, the Dr Kathie Bull Reports). These failures led to the continuation of outdated policies and practice, inadequately trained staff, poorly resourced services and failures to safeguard children.

12.92 The Inquiry also heard of occasions on which the island has responded to developments in child care policy and practice elsewhere, such as the implementation in England and Wales of the *Children Act 1989*, or the findings in 2003 of the Victoria Climbie Inquiry. However, it has done so selectively – for example, not adopting significant underpinning policy and practice guidance or key legislative elements (such as the concept of "child in need") – or has taken elements out of context and misapplied them (as with the concept of so-called "Laming compliance", which, as the Panel has clarified with Lord Laming, was neither a recommendation nor an intention of the author of the Victoria Climbie Report). These well-intentioned attempts to follow international developments in child care policy and practice have been unsuccessful, we have concluded, due to a lack of social policy expertise and capacity, and a lack of skilled leadership in Children's Services. This has been operating alongside a long-term political failure to prioritise the welfare of children and the provision of high-quality services for vulnerable children and families.

12.93 We recognise that Jersey also may not always have been well served by some of the external assistance that it has sought. Concern was expressed during the Inquiry that some reviews that Jersey has commissioned may not have been sufficiently robust or independent. Jo Olsson, former interim Director of Children's Services, told the Inquiry:[22]

> *"The danger of an overly managed process leading to a whitewash must be avoided. Some partners reported this was their judgement of the Scottish Inspectorate reports. Children's Services in Jersey absolutely needs independent oversight."*

12.94 The establishment of this Inquiry, and the freedom with which it has been allowed to operate, has demonstrated a political will and public desire in the

[22] WS000714, paragraph 77c

island to open Jersey's institutions to thorough, independent and robust scrutiny in order to secure the best interests of children and to learn how best to build safe and effective services in the future. It is the Panel's view that this approach must continue to characterise the island's response to independent inspection and review.

12.95 Sometimes Jersey has received advice and recommendations that were unlikely to deliver the outcomes needed, because they did not adequately identify or grasp the extent of systemic problems. For example, the Williamson Report and the Social Work Inspection Agency (SWIA) Reports focused predominantly on developing processes, structures and procedures instead of identifying and setting out a roadmap for pursuing desirable outcomes and for transforming service users' experience. Instead, their recommendations predominantly allow actions to be checked off without addressing underlying failings in the child care system.

12.96 The problems in Jersey have been compounded by a failure in the island's legislative and executive institutions to grasp the speed with which policy and practice develop in child care. Reviews and recommendations essentially have a shelf life because new research and new approaches are always emerging to meet new challenges and better address existing ones. Jo Olsson told the Inquiry[23] that she was "perturbed" that, in 2014, Jersey was still relying on the 2008 Williamson Report and ongoing efforts to implement it as evidence of progress. She found it "quite shocking" that, as late as the summer of 2015, professionals and politicians were still taking reassurance and trying to work through recommendations from not only the Williamson Report (2008) but also the earlier Dr Kathie Bull Report (2002). She had observed the same problem with recommendations from SCRs and was concerned by Jersey's history of producing "superficial" action plans that were never going to effect the real and necessary changes required.

12.97 The Panel received compelling evidence to support her concerns. In closing submissions, the States of Jersey advised[24] that, since 2010, over 200

[23] Day 138/196/2
[24] Day 145/36/5

recommendations had been made in SCRs, of which 50% had been implemented and 25% were in the course of implementation. Some of these recommendations related to cases going back to the 1990s, since which time policy, thinking and practice in child care in the developed world have changed significantly, and the momentum continues apace as new research and new models emerge. Working through a list of recommendations from up to six years ago, in order to address issues that may date back a quarter of a century, will not bring about the substantial improvements required in children's safety, experiences of state care and quality of services in Jersey.

12.98 Julie Garbutt, Chief Executive of the Health and Social Services Department (HSSD), told the Panel:[25]

> *"We have for a number of years pursued a number of action plans on the back of the Williamson Report originally and then the Care Inspectorate Report and we believed we were making good progress, nonetheless it was quite clear from about the middle of 2014 onwards that our aspiration was not being met by real change on the ground and our understanding of our real challenges was only starting to emerge … ".*

12.99 It is a matter of some concern to us that it was only with the intervention of Julie Garbutt and the appointment of Jo Olsson that the true extent of the inadequacies in child care policy and practice was recognised. A contributor to the Breckon Report, six years earlier, had commented:[26]

> *" … the Williamson Report precipitated a large spend of time and money on the organisation of the department at a managerial level; however it forgot the coalface workers … where the difference to children and families is made …".*

12.100 The Scrutiny Panel responsible for the Breckon Report also expressed concern in 2009 about the response by Children's Services to the Williamson Report being investment in management structures instead of addressing "*the inexorable decline in both staff morale and the standard of service delivery"*.[27] The Panel endorses those concerns.

[25] Day 142/48/9
[26] WD007195/254
[27] WD007195/256

12.101 Furthermore, by 2014, a decade of SCRs had documented, for politicians, professionals, the public and the Jersey Safeguarding Partnership Board (JSPB), the consequences for children ill served by the services that were supposed to care for and protect them. SCRs commissioned and published from 2004 onwards describe failures in child protection processes dating back to the 1990s: children left in abusive situations and harmed; children who were not listened to; children whose distress was not recognised; and staff who were ill equipped, inadequately supervised, poorly managed and, at times, unable to protect children. The same problems were highlighted to the SPB in SCR after SCR. As the Board and its constituent agencies continued to generate and work through SCR recommendations, nothing changed for some children in Jersey, who remained in dangerous or distressing situations that simply became the subject of more recommendations when another SCR was commissioned because something else had gone badly wrong.

12.102 The Panel has seen from the current political leadership in the island evidence of a genuine commitment to delivering quality services for Jersey's must vulnerable children. This commitment must be matched with new mechanisms for the delivery of change and for creating and sustaining effective child welfare policies and skilled professional practice. Jersey's traditional approaches to taking forward recommendations, which have relied on Children's Services managers and broadly targeted goals and resources, have proven to be insufficient in the past. Securing the substantive improvements in child safety and in the wellbeing of vulnerable children to which the political leadership and the wider community in Jersey aspire will need new mechanisms for the delivery of change. Key features of such mechanism might include:

- a central unit, based within the Chief Minister's Department, to aid the development and delivery of policy and to promote a co-ordinated approach to child care policy in Jersey;
- clear and specific outcomes of quality and quantity being set for how children and families experience the care system;
- setting and monitoring staff performance levels;

- monitoring of the impact of changes by obtaining feedback from key stakeholders, including from the voluntary sector, from Parishes, from families receiving services and from care-experienced young people.

12.103 As part of this process, it is important that those responsible for both policy and practice development in relation to Children's Services develop close links with agencies (in all sectors) in other jurisdictions that are recognised as high-quality providers of children's services and also with leading research institutions in the areas of child care policy and practice. The Inquiry has heard evidence of how the SOJP and the Probation Service have benefited from close links with other jurisdictions that have ensured that standards and practices have developed in line with modern thinking.

12.104 It is crucial that external partnerships are chosen carefully and are developed with agencies with an outstanding track record of successful outcomes in child care policy and practice and an international reputation.

12.105 Julie Garbutt told the Panel:

> *"The States … don't disregard things completely. There will always be a plan and there will always be some money generally attached to it. The problem being that it isn't always the right plan and it isn't always rigorously monitored in terms of its outcome and it isn't usually enough money …".*

12.106 We recognise that our recommendations must address the fundamental problems that Jersey faces in order to keep its children safe, and must assist Jersey to develop the "right plan", rigorously monitored, to achieve that outcome. The "right plan", and even the best-drafted recommendations, however, will fail if the mechanisms established to implement them, and to take forward the programme of improvement in child care, have the same intrinsic operational flaws that have compromised the effectiveness and professionalism of services for children over many decades in Jersey.

12.107 It is vital that the mechanisms in Jersey responsible for the ongoing transformation of child care, including the implementation of the Inquiry recommendations, should:

- no longer prioritise the job security of staff ahead of the welfare and best

interests of service users, including children;

- no longer appoint or retain managers who are unable to recognise failing standards and who may not even know “what good looks like”;
- tackle poor performance at all levels of service management and delivery;
- no longer invest in or deliver models of care and practice that have failed children for decades;
- seek out, follow and keep pace with good policy and practice developments in child care as they evolve within internationally recognised centres of excellence.

12.108 These features must be evident, and independently verifiable, at all levels in the mechanisms taking forward Jersey’s programme of transformation, wherever they sit within the States of Jersey’s functions and operations (for example, Chief Executive’s Office, HR, Chief Minister’s Office, HSSD). If the underpinning framework for delivery of change is compromised by unprofessional and outdated values and practices, then the recommendations and the efforts of staff and managers will be unable to deliver what Jersey’s vulnerable children need.

12.109 The evidence that the Panel heard suggests that, as of 2016, some children known to or in the care of the States of Jersey remained at risk of harm because of inadequate assessments and poor practice and performance in Children’s Services. For the sake of these and future children, the States of Jersey must not allow the status quo to persist. The key changes required are not procedural but cultural. The States of Jersey must commit to and invest urgently and vigorously in a new approach to overseeing, supporting, developing, delivering and scrutinising its services for children.

12.110 The new “Jersey Way” that it establishes will be characterised by intolerance of poor performance; high aspirations for every child in the island; commitment to securing the best-quality services to enable disadvantaged children to have equal opportunity to fulfil their potential; and creating a culture in which staff development is valued and promoted. The Panel

considers Jersey's readiness to invest in interim specialists, to identify fully and accurately the depth of problems in its child care services and to begin the work of transformation to be a welcome indicator of political and public will to improve outcomes for vulnerable children in the island.

Ensuring an effective response and successful outcomes: the experience of other inquiries and research on recommendations

12.111 The Panel was keen to understand the factors that promoted an effective response to the recommendations of inquiries and delivered successful outcomes for children. As part of Phase 3, the Panel consulted with members of past and previous inquiries set up in the UK and allied jurisdictions (including Lord Laming; Professor Alexis Jay; the St Helena Inquiry; the Historic Institutional Abuse Inquiry in Northern Ireland; and the Scottish Child Abuse Inquiry) to discuss the challenges of translating inquiry findings and recommendations into improvements in services for children. The Inquiry also had regard to research into Inquiry recommendations and their successful implementation commissioned from the Parenting Research Centre (PRC) by the Australian Royal Commission into Institutional Responses to Child Sexual Abuse.[28]

12.112 The consultation with other inquiries and past and present inquiry chairs produced principles that accorded with the research undertaken by the PRC into inquiries in Australia and elsewhere, which concluded that successful implementation of inquiry recommendations is contingent on:

- the scope of the inquiry and the inquiry process;
- the nature and pertinence of the recommendations;
- the commitment of governments to implement the recommendations;
- community attitudes;
- the role and support of the media;

[28] Parenting Research Centre (2015), *Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse.* Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney

- the decision to implement by government;
- monitoring and evaluating of the implementation process.

12.113 The Panel is encouraged that most of these key elements underpinning successful implementation of recommendations are already in place in Jersey:

- From the outset, the Inquiry has asserted its independence, focus on children and need for transparency.
- The Inquiry was given wide terms of reference that were pursued, unfettered by government intrusion or oversight.
- The Chief Minister, the Minister for HSS, and key officers such as the Director of Education, impressed the Inquiry in the sincerity of their desire to secure for children in the care of the States the same benefits and opportunities that they would want for their own children and grandchildren.
- Politicians and senior officers of many departments, including Children's Services, Health, Police, Probation and Education, agreed the need for an ongoing programme of scrutiny, monitoring and evaluation of future progress and developments.
- The Jersey media had played an important role in reporting Inquiry proceedings and publicising appeals for witnesses and Inquiry consultations with the public. The local media will also have a role in publicising the Inquiry recommendations and reporting on progress. Social media has also played an important part in reporting the Inquiry's progress, and will continue to comment on progress.

12.114 The PRC research stressed the importance of "community attitudes" in ensuring that recommendations are effective, and found that a facilitating factor in promoting the uptake of recommendations was "early and ongoing consultation with relevant stakeholders". Stakeholders in Jersey include looked after children, professionals in the voluntary and States-run sectors, politicians, voluntary agencies and the wider community of Jersey citizens.

How the Inquiry has used the learning from other inquiries and research in developing recommendations

12.115 From its earliest days, through all the phases of the Inquiry's hearings, we have sought views and recommendations from witnesses on the future of child care services in Jersey. The Panel has also conducted, in parallel to its hearings, an extensive programme of visits and meetings with stakeholders: individuals, service providers, volunteers and organisations working in Jersey or with experience relevant to Jersey. We have also carried out consultations in Jersey with voluntary-sector organisations, statutory agencies, politicians and members of the public.

12.116 As a result, we have gathered suggestions from people with direct experience of being in the Jersey care system from the 1940s, through to young people currently living in foster care or residential care in Jersey; from families of former residents; and from people who worked in, managed or planned services for children. In those meetings, visits and interviews, and in Phase 3's public hearings, we have had the opportunity to discuss issues that were emerging from hearings, recommendations that had been offered or that we were considering with some of the people who would be most directly affected by them or closely involved with implementation. We have also consulted experts in areas covered by recommendations, such as advocacy for children, residential care, raising standards of performance and improving outcomes for children. These interactions with stakeholders and others helped us to shape, modify and refine recommendations and to consider matters that may assist in their implementation.

12.117 Phase 3 has also allowed the Inquiry an opportunity to invite different stakeholders, agencies and individuals to comment on emerging recommendations and suggestions. Every Inquiry recommendation has been put, in some form and at some stage, to key stakeholders, and has been refined by their responses. There are neither magic solutions nor surprises in the recommendations. It is our view, supported by the experience of other inquiries and by the PRC research, that the grounding of our recommendations in the realities, knowledge and experience of key

stakeholders in Jersey will be a strong factor in ensuring their successful adoption and implementation.

12.118 We believe that two further elements are required to ensure the effective implementation of our recommendations and to avoid some of the shortcomings in the response to past reports and recommendations. First, responsibility for implementation should not lie with individual departments, agencies or current structures but rather be overseen by a specialist child care policy and standards unit based within the Chief Minister's office, with sufficient authority and resources to promote and monitor the rapid and successful adoption of recommendations. Secondly, the progress of implementation of recommendations should have an element of independent oversight, and success should be judged on the outcomes for and experiences of children and families as well as on staff capacity and development.

12.119 Based on our understanding of Jersey's history and of identified good practice in framing recommendations, the approach that we have taken in framing recommendations is:

- **Focus on essentials.** We want to avoid giving the States of Jersey a lengthy checklist of recommendations. History suggests that this could result in departments marking off superficial achievements without addressing underlying significant systemic problems, or it might cause pre-occupation with the detail of a large number of recommendations and fail to see the bigger picture.

- **Not overly prescriptive.** For each recommendation, we set out key requirements, the principles that should underpin them, some desirable features and some suggestions as to how each recommendation should be monitored and how success should be evaluated. We have avoided descending into the detail of each step and every feature of each recommendation, believing that these aspects should be determined locally and, where possible, flexibly integrated into existing successful initiatives. We consider that the most effective way forward will be for people in Jersey to develop Jersey ways of taking forward the principles of our

recommendations. **The Panel commends to the States of Jersey detailed consideration of the suggestions, recommendations, offers of assistance and resources offered by organisations and individuals invested in improving services and opportunities for children in Jersey (Appendix 3).** It also notes the comprehensive staff development strategy proposal submitted by Janet Brotherton as part of the Phase 3 consultation.

- **Geared to address issues of culture, leadership, values and standards.** Many attempts at change, service development and transformation in Children's Services have failed because of a pre-occupation with processes and procedures rather than with cultural change and the delivery of outcomes that improve the safety and wellbeing of children. Decades of ineffectual strategies and practices will never be transformed by simply repeating them in different guises or by proceduralising them.

- **Holistic.** The Australian research shows that the most effective recommendations are interconnected and reflect how the whole system works. Thus, our recommendations do not simply cover the function of Children's Services, but also reflect wider social policy and legislative considerations.

- **Mindful of capacity.** Our approach is built around encouraging Jersey to build on and do more of the small number of things that are working well. The Panel has had regard to current and proposed future investment in services for children and to the prevailing financial climate.

Building recommendations from the hopes and aspirations of Jersey's people

12.120 When formulating recommendations to address the causes of the 10 systemic failings we identified in Jersey's care services, we drew on the extensive Phase 3 consultation exercise that we have undertaken and all the material, suggestions, criticisms, views and advice that we gathered in that process, as well as findings and recommendations from Phases 1 and 2 of the Inquiry.

12.121 We drew on recommendations and observations from: over 50 witnesses in Phase 1 and 2 hearings; 72 Phase 3 meetings with over 100 participants;

Phase 3 consultations and public hearings involving 23 members of the public and organisations representing around 3,500 people in Jersey; and contributions in public sessions from 20 politicians and senior managers. From this process, we received **659 individual recommendations**, as detailed in Appendix 3.[29]

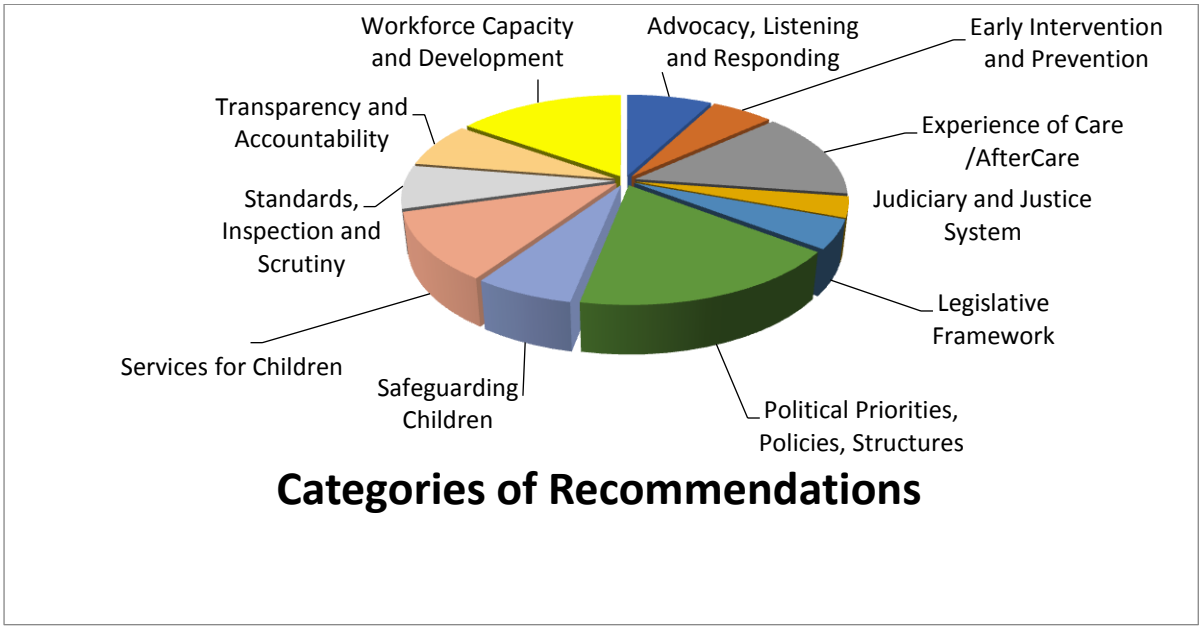
12.122 We were struck by the strong consensus in these recommendations and by the insight, compassion and the commitment to Jersey's children that they evidenced from across Jersey's community. We found that the 659 recommendations we received could be grouped into 11 categories or themes:

- Advocacy, Listening and Responding;
- Early Intervention and Prevention;
- Experience of Care/Aftercare;
- Judiciary and Justice System;
- Legislative Framework;
- Political Priorities, Policies, Structures;
- Safeguarding Children;
- Services for Children;
- Standards, Inspection and Scrutiny;
- Transparency and Accountability;
- Workforce Capacity and Development.

12.123 The distribution of these themes is shown in Figure 12.1.

[29] The recommendations are listed anonymously, to avoid particular status or significance being given to the individuals or organisations that provided them. They are presented neutrally, with each recommendation having equal validity. The Panel addresses, at the conclusion of Appendix 3, the very small number of these recommendations that it would not support

Figure 12.1: Categories of recommendations



12.124 The 659 recommendations derive from thoughtful, creative suggestions and observations from people with a stake in Jersey delivering safe and successful services for its children. Even where there was occasional disagreement on solutions (for example, on whether Jersey should have a Children's Minister, a Children's Ombudsman, a Children's Commissioner or all three), there was agreement about the underlying issues to be tackled (in this example, the need for political leadership of and accountability for children's services, independent scrutiny of services and advocacy for children). There was also agreement about key features of the solution (i.e. high-level political involvement with authority to drive policy, independent, external scrutiny and an independent, powerful figure to enable the experiences, concerns and voices of children to be heard).

12.125 We have distilled these contributions, our findings on the Terms of Reference, the lessons to be learned and consultation material into **eight recommendations**, set out in Chapter 13.

12.126 We believe that these recommendations reflect aspirations in Jersey's community for the future of children's services and offer a sound approach to addressing the problems that have long beset Jersey's child care services. We also believe that they offer a strong opportunity for redeeming the heritage

of Jersey's care institutions and transforming it into a legacy of safe, nurturing care for future generations of Jersey's children.

CHAPTER 13

Recommendations for the States of Jersey

13.1 In considering the recommendations that we should make at the conclusion of the Inquiry, we have taken into account our findings and the valuable advice that we have received from many witnesses. We have included as an appendix to our Report (Appendix 3) a list of some 659 recommendations that emerged from the evidence we received and consultations we undertook over the course of the Inquiry. Many of these reflect a consensus among our witnesses as to what needed to be done to move forward from the Inquiry and the history in a positive way that will ensure that the mistakes of the past are not repeated. We commend all of these recommendations as being worthy of serious consideration, albeit that some may not be found to be feasible for implementation. However, they should inform the thinking and debate that must follow on from this Report.

13.2 In setting out its recommendations, the Panel has taken the view that it will be more helpful to make a small number of high-level proposals rather than many points of detail. We consider that it is essential that the people of Jersey determine how to make the necessary changes in ways that will work best for the current and future children of the island.

13.3 We recognise that all of our recommendations will require detailed consideration as to how to take forward implementation, and that some will be challenging since they require a movement away from long-established systems of governance and practice. However, it is our firm view that unless these changes are made, there can be no assurance that the failures of the past will not be repeated.

13.4 Jersey now has the opportunity to put itself at the forefront of care for all of its children, and in particular for those who face adversity in their young lives irrespective of how that manifests itself. Our work has revealed failures of care over many years that must be acknowledged and that require bold changes if they are to be seen as part of the past, with no place in the future.

13.5 Our findings and recommendations require action without delay. Too often, the island has commissioned reports that have raised important issues requiring change and investment, but has failed to act on them. This must not happen with this Report, since it concerns not only the recognition of the damaging past but also the future wellbeing and safety of the island's children and young people. To that end, we propose that an arrangement be put in place independently and publicly to review progress in two years' time.

13.6 These recommendations are of equal importance, and are made in no particular order.

Recommendation 1: A Commissioner for Children

13.7 There was wide support for the appointment of an independent Commissioner to have responsibility for the oversight of all matters concerning the welfare and wellbeing of children and young people in Jersey. A consistent theme from those who were supportive of this idea was that there was an absolute need to ensure that any such position was seen to be fully independent of the States. Accordingly, **we recommend that the post of Commissioner for Children in Jersey be established and enshrined in States' legislation** in a manner consistent with the UN Principles Relating to the Status of National Institutions (the Paris Principles). The Commissioner's primary function would be to promote and protect the rights of children in the island.

13.8 Each of the four countries of the UK has a position of this kind, established by legislation. In England, the post of Children's Commissioner was created under the *Children Act 2004*. The *Children and Families Act 2014* gives the Commissioner special responsibility for the rights of children who are in or leaving care, living away from home or receiving social care services. The Republic of Ireland has a post of Ombudsman for Children, with similar responsibilities. While the legislation in each jurisdiction varies, all post holders have a similar responsibility for safeguarding the rights and interests of children. All have a duty to have regard to the United Nations Convention on the Rights of the Child (UNCRC), to which Jersey is now a signatory.

13.9 The Commissioners are appointed by differing mechanisms in each country. However, it appears to the Inquiry that, in the interests of independence, any such appointment in Jersey should be made by the States Assembly rather than by Ministers. **It will be important to seek candidates of the highest calibre who have a sound track record of commitment to serving the best interests of children and young people, and who will be seen as being fully independent of government.** Any interview panel that is set up for the purpose of making a recommendation to the States Assembly should include young people, at least one of whom should have experience of the care system. As in the UK, the appointment should be made on the basis of the Commissioner serving no longer than a six-year period of office. Any mechanism for the removal of the post holder in exceptional circumstances should require the approval of the States Assembly.

13.10 None of the Commissioners has a power to investigate individual cases, and it would seem appropriate to have a similar arrangement in Jersey.It is essential that there is a clear means for looked after children to raise complaints and receive a response from those responsible for their care. The Commissioner should have oversight of such arrangements. We noted that the Commissioner in Wales can assist a young person in making a complaint about any regulated service, which is something that could be considered in Jersey.

13.11 **It is essential that the Commissioner should have an unfettered right to make public the findings of any Inquiry undertaken by him or her.** There should be a responsibility to present an annual report. To ensure that this does not become simply a ritualistic paper exercise, the Commissioner should have the right to present the report directly to the members of the States Assembly without any oversight by Ministers. To ensure that action is considered in respect of any recommendation made by the Commissioner, a duty should be placed on the Chief Minister to make a public response to the States Assembly, indicating what action is proposed to be taken.

13.12 To underline further the independence of the Commissioner, and to broaden the field of experience, **the Inquiry recommends** that the States of Jersey

should explore the possibility of creating this as a joint appointment with other jurisdictions. There may, for instance, be some scope for making an appointment with responsibilities across other Crown Dependencies. This would have the potential to facilitate the sharing of practice among jurisdictions. While there would be one Commissioner, we envisage that staffed offices of the Commissioner would be located in each of the jurisdictions served. The exploration of the feasibility of an intra-Crown Dependency Commissioner for Children should not, however, result in any delay in moving to the statutory appointment of a Children's Commissioner for Jersey in the first instance.

13.13 **We recommend** that, in pursuing this matter, the States should give consideration to the merits of the arrangements of the various Commissioners across the UK and Ireland, with a view to establishing what would serve the interests of all children in Jersey to the greatest effect. Those arrangements should include giving the proposed Commissioner special responsibility for the rights of children in Jersey who are in or leaving care, living away from home or receiving social care services. At present, the Commissioners and Ombudsman from the UK and Ireland meet as the British and Irish Network of Child Commissioners (BINOCC). **The Inquiry considers that it would be important and advantageous** for any Commissioner appointed in line with our recommendation to seek to become a member of this network.

Recommendation 2: Giving children and young people a voice

13.14 Ensuring that the voice of children and young people is heard in relation to all matters affecting their lives, including the development of government and service policy, is crucial to building confidence that their interests are given paramount consideration. The **appointment of a Commissioner** will be a crucial step. However, there are other mechanisms that we consider to be important to sit alongside the role of a Commissioner.

13.15 The Inquiry heard from young people in Jersey with experience of the care system that, while they were aware of a complaints system being in place, they found it difficult to operate, and their experience was that there was usually no satisfactory outcome to any complaint that they raised. The Inquiry

considers this to be unsatisfactory: if young people do not have confidence in the system, the risk is heightened that significant issues fail to come to light and that opportunities to take early action are missed. **We therefore recommend** that the complaints system be reviewed with a view to ensuring that it is easily accessed and that clear responses are always made to complainants within set timescales. **We recommend** that the outcomes of complaints investigations should be reported regularly to the relevant Minister, who must be required to present a report on complaints to the States Assembly on an annual basis.

13.16 In order to assist looked after children to raise complaints and matters of concern, **we recommend** that a **Children's Rights Officer** should be appointed, reporting directly to the Managing Director with responsibility for Children's Services. Posts such as this have long been in place in the UK and have done much to ensure that the rights and interests of children are given proper priority within services. Such officers ensure that children and young people with experience of the care system, irrespective of where they are accommodated, are able to have their voices heard and to ensure that they receive appropriate responses to the matters that they raise. This is not to say that all complaints are upheld or that all matters raised are agreed, but, where a positive response is not possible, it is vitally important that this is clearly communicated to the young person, along with the reason. The Children's Rights Officer has an important role in ensuring that the young person is able to understand the response that he or she has received. An important element of the role of Children's Rights Officer is to promote an understanding, across the workforce, of how children and young people express themselves, particularly when there are matters that are troubling them.

13.17 In addition to the appointment of a Children's Rights Officer, **we recommend** that there is engagement with a service such as "Become" (formerly the Who Cares? Trust), a charity for children in care and young care leavers, that can provide external support and advocacy.

13.18 We found it extremely helpful and informative to meet with young people within the care system in Jersey and to hear of their experiences and the

matters that concern them. **We therefore suggest** that the Chief Minister in Jersey may find undertaking similar meetings to be informative in taking forward the outcome of this Inquiry. We believe that this would send a powerful message of commitment from the highest political office to ensuring that children's and young people's voices are heard.

Recommendation 3: Inspection of services

13.19 Jersey has no statutory requirement for its services for children to be inspected independently. There were no external inspections of Jersey's Children's Service between 1981 and 2001. Notwithstanding this, there have been occasions when inspections have been arranged by invitation, such as when the Scottish Social Work Inspection Agency/Care Inspectorate undertook an inspection in 2011 and then a follow-up review in 2013. These inspections arose from a recommendation in the 2008 Williamson Report that suggested annual or bi-annual inspections. While this must be viewed positively, it is not the same as having in place a statutory body with responsibility and power to inspect services. The obvious risk of the current arrangement is that it depends entirely on an invitation being extended by those responsible for services: if no such invitation is made, then services and the people who use them miss out on rigorous external scrutiny. This is an unacceptable situation that the Inquiry considers should be rectified without delay. **We consider that it is essential that services in Jersey are willing to open themselves fully to external scrutiny, in the interests of ensuring continuous improvement and development.**

13.20 We consider that it would not be feasible for Jersey to set up an inspection agency located in the island, since this would be likely to be viewed with suspicion as to its independence. **We recommend**, therefore, that the States commits to introducing an independent inspection regime for its Children's Services. It must give urgent consideration as to how it can establish an arrangement that will have the confidence of islanders, and especially looked after children. Options for doing this could include commissioning from an off-island agency such as Ofsted. This could bring some cost efficiencies and would create opportunities for the sharing of ideas and practice across the

varying jurisdictions. It would also offer an important developmental opportunity for staff within services to have short-term secondments to participate in inspections in other jurisdictions. A development of this kind would not, of necessity, have to be free standing, but could be established as a specific unit within an established inspection agency such as Ofsted. This would allow it to gain valuable experience without it having simply to apply the standards and mechanisms that Ofsted has in place for the jurisdictions that it covers at present. It may be that there are other relevant agencies, such as some of the large-scale third-sector providers, with whom a partnership could be formed to deliver the inspection function, provided that a clear model of inspection was put in place from the outset. It is not for the Inquiry to prescribe how this should be established, but **we do emphasise the urgent need to take forward a credible arrangement for inspection**.

13.21 There is no current legislative basis for inspection: we do not consider that this is a hindrance to an inspection arrangement being made on a voluntary basis in the first instance. **The Inquiry recommends that, at the first opportunity and in any event within 12 months of the date of the publication of this Report, a statutory basis for inspection of Children's Services be established.** This must require inspections to be undertaken on a regular basis, on both announced and unannounced bases. Inspectors must have powers of access to all relevant premises, documents and staff at all times. Inspection reports must be made publicly accessible, as should the responses made to them by inspected services. In establishing the inspection arrangements, **we recommend** that the system that is put in place should be one that supports learning rather than rigid compliance. The quality of services cannot be assured by inspection alone, but requires a whole-system approach, including such elements as robust reflective supervision and peer review.

13.22 Once the inspection arrangement is in place, **we recommend** that the current Independent Visitors for Young People (IVYP) arrangement should be terminated. While we were impressed with the understanding and commitment of the independent visitors we met, we were also concerned about their perceived lack of power. It would be an unnecessary duplication if

the IVYP remained in place alongside an inspection agency, and could result in excessive intrusion into the lives of looked after young people. It would, however, be appropriate, and therefore **we recommend** that the States makes use of experienced independent visitors by involving them as lay inspectors in inspection teams. It would also be important to involve young people with experience in care within inspection teams, as has been developed, for instance, by the Care Inspectorate in Scotland.

13.23 The Inquiry considers that having an empowered and effective regulatory and inspection regime in place is an essential component of ensuring the safety and wellbeing of children and young people who are looked after. We consider that having an inspectorate working alongside a Commissioner and support for young people to have a voice that is listened to would be very significant steps towards building confidence in services for the long term. Speedily establishing this triumvirate of Inspectorate, Commissioner and Children's Rights Officer would signify the States' commitment to ensuring that the failures and inadequacies of the past are not repeated.

Recommendation 4: Building a sustainable workforce

13.24 The Inquiry was very concerned to hear of the difficulty that had been experienced over many years in recruiting and retaining suitably qualified and skilled staff at all levels within Children's Services, including residential care staff. The service has had too many short-term interim senior managers. In our last sessions of Phase 3, we heard of high expectations being built around the latest appointment of a Director of Children's Services. We were therefore concerned to learn, after our hearings had concluded, that this person had left the service and the island after only five months in post. This is a very destabilising situation that **we suggest** must be resolved as a matter of urgency. Without a stable workforce at all levels, service users are unlikely to have confidence in the service that they will receive and, without stability at senior management level, staff are unlikely to feel confident in the way that they are supported to undertake their complex and difficult tasks. If there is a constant turnover of staff, it is impossible to build a consistent high-quality service on which the public can rely. Children and families who feel as though

they never see the same social worker twice can hardly be expected to have a trusting relationship with the service.

13.25 We heard evidence that senior managers in Children's Services did not find the Civil Service Human Resources (HR) section to be helpful. We were told that there was a need for HR processes that would enable managers to manage performance more readily and more robustly. It is essential that HR staff supporting Children's Services understand the needs and responsibilities of the service, and in particular that the welfare and safety of children is the paramount consideration. **We recommend** that Children's Services be provided with a **dedicated specialist HR resource** to work alongside managers in building a stable and competent workforce. It may be the case that consideration will need to be given to wider matters, such as whether the current residency rules require variation in order to facilitate recruitment to this field.

13.26 We were impressed by what we heard from the Chief Probation Officer as to how he had created a much more stable staff group that had an emphasis on high practice standards, underpinned by consistent training both on and off the island. We were surprised that there did not appear to have been any exchange of thinking on this between Children's Services managers and the Probation Service. In a small professional community such as exists in Jersey, the sharing of experience and learning should be commonplace. **We therefore recommend two things**. First, that a plan for the recruitment and retention of staff be put in place, taking into account the positive experience that there seems to be in the Probation Service. Secondly, we strongly emphasise the need to develop a culture of corporate working across all public services. This must be led by senior politicians and by the Chief Executive and his senior team.

13.27 In developing a plan for the recruitment and retention of staff, we recommend that consideration be given to a range of ways in which services can be provided. **We suggest** that this should include the possibility of commissioning services from other agencies such as large third-sector providers or, indeed, south of England local authorities. This could, for

instance, give access to wider resources for training and practice support. It would also open up possibilities for staff working in Jersey to gain wider experience and to keep pace with practice developments in other jurisdictions.

13.28 In the course of Phase 3 we met with Professor Eileen Munro and visited the London Borough of Hackney, which has undergone transformational change in the way in which its social services operate. Hackney was previously viewed as having significant problems in its services, but, as a result of changes made to its structure and methods of working (influenced in no small part by Professor Munro), it is now viewed as providing very high-quality services. One result of this change is that whereas, previously, it found it difficult to attract staff and to retain them, it is now able to fill all vacancies and, indeed, attract more good-quality applicants than it has posts. **We recommend** that the States should conduct a review of how Hackney has implemented changes, and consider how to effect best practice in Jersey's Children's Services. The leaders we met in Hackney were at pains to emphasise that "*you cannot simply pick up the Hackney model and transfer it to your service*". They stress that the way forward is for services to develop their own models, just as they did, and thereby to have ownership of them.

13.29 In addition to meeting with Professor Eileen Munro, we met with Isabelle Trowler, the Chief Social Work Adviser for Children's Services in the Department for Education (DfE). She had previously held a senior management post at Hackney and had been a key participant in leading the change process there. In our discussion with her, she shared our concern that too much emphasis was being placed on process as a means of protecting children, rather than on the delivery of effective interventions. Our concerns about this grew as we heard evidence in Jersey that similarly tended to focus on process in the form of various meetings rather than professional practice. In Phase 3, we formed the view that many of the changes seen as being a priority were solely concerned with process rather than professional practice. We understand and accept that some elements of process are essential, but the thing that will make the difference to the lives and safety of children is the quality of the intervention that services make to support them. There is a danger of implying that if a plethora of meetings is held and forms filled in,

children will be protected. This, in our view, is not the case. Effective professional practice must be underpinned by safe recruitment, access to high-quality training and reflective supervision.

13.30 Foster carers, though not part of the workforce, are a key part of the provision of Children's Services and can make a very significant positive difference to the experience of looked after young people. During Phase 3, we heard of considerable dissatisfaction among the island's foster carers, who felt that they were not viewed as being "*part of the team*". They told us that they had "*to fight all the time over little things and big things*". We heard from the Chief Executive of the Fostering Network, the UK's leading fostering charity, that, in his opinion, Jersey was at "*the very lower end of what* [he] *would hear from foster carers in terms of practice*". Given the importance of fostering as a resource, these comments give rise to concern and point to the need for improvement. **We recommend,** therefore, that a thorough review of fostering in the island is undertaken as a matter of urgency, and that external expertise is engaged to assist with this. **We recommend** that the review should examine the recruitment and retention of foster parents and must consider whether any arrangements need to be made to ensure that families with the potential to be effective foster carers have access to suitable housing. The review must set the groundwork for a different attitude to foster carers from professional staff that should ensure that foster carers are treated fully as equal members of the team looking after children in the care system alongside those employed professionals working in Children's Services.

Recommendation 5: Legislation

13.31 During the Inquiry, we heard that legislation for children in Jersey was almost invariably lagging behind positive developments in the UK and beyond. To a large extent, this seemed to be related to the fact that there is no separate policy division to deal with this within the Civil Service, with the result that the development of new legislation is dependent on Children's Services managers, whose primary responsibilities are operational, being able to devote time to the task. In addition, priority is given within the States to legislation related to the island's economy, with the result that children's

legislation can take a considerable time to be agreed. It was accepted by the States of Jersey in its closing submissions that *"in the area of legislation and policy, there is still a significant amount of work required".*

13.32 While we recognise that resources to support the legislative process are limited in the small jurisdiction of Jersey, it is unacceptable for the island's vulnerable children and young people not to have their wellbeing looked after. The principle of the paramountcy of the child's welfare is long established in children's legislation, and lip service seems to be given to this by the States of Jersey. If the failings of the past are to be avoided, it is essential that these matters are given a prominent position in the legislative process, to ensure that the interests, safety and wellbeing of children have the most modern legislative backing.

13.33 **We recommend** that consideration be given as to how the island can have a more effective mechanism for developing legislation, policy and practice guidance in relation to children and young people. If, for instance, operational services were commissioned from an external agency, a small policy unit would be necessary within the Jersey Civil Service to develop the policy and guidance under which the commissioned service would be expected to operate. It is also possible to buy in expert resources from relevant third-sector agencies to support this.

13.34 An alternative approach would be to put in place an arrangement whereby Jersey speedily adopts suitably adapted legislation and guidance from a larger jurisdiction such as England. This would require working in parallel with relevant departments in England as legislation or guidance is developed. The Inquiry recognises that this is not an easy matter to deal with, given the legislative independence of the island.

13.35 The Jersey youth justice system continues to be court based and, while some revisions to practice seem to have been made, **we recommend** that a thorough review be undertaken with a view to moving to a **welfare-based model** rather than a punitive one. We heard from witnesses that the *Criminal Justice (Young Offenders) (Jersey) Law 2014* should have a section inserted into it recognising that the welfare of children should be a primary

consideration. We agree with this, but our view is that this, in itself, would not be sufficient unless the whole system were amended to centre on the welfare of the child. **We recommend** that the Youth Justice System should consider how it can move to a model that always treats young offenders as children first and offenders second.

13.36 In our view, it is essential that those charged with dealing with children and young people in a judicial capacity should have a sound understanding of the needs of young people and of the issues that can impact on their lives. To that end, **we recommend** that a suitable programme of training be put in place for all those acting in a judicial capacity in the island, and that there should be a requirement for regular refresher training to ensure that all are kept briefed on the latest thinking and research on these matters.

Recommendation 6: Corporate parent

13.37 We regularly heard reference to the "corporate parent" in evidence relating to recent years, but it was often unclear what was meant by this. While many witnesses seemed committed to the idea, there seemed to be little evidence of a full commitment to the concept that children looked after by the States were entitled to have the full resources of the States applied in their best interests throughout their time in care and, indeed, beyond. We heard that a briefing session about the role of the corporate parent was held for States members after the 2014 election, but that it was attended by very few members. We consider this to be unacceptable, given the paramountcy principle. **We therefore recommend** that, for the future, attendance at such a briefing is made mandatory for all members following an election and that this should be followed up by at least annual refresher training. All States members must understand the weight of responsibility that they collectively carry for all children who find themselves in public care. To emphasise further the commitment to corporate parenting, **we further recommend** that reference is made to this specific responsibility in the oath of office taken by members of the States Assembly. The symbolism of this would, we believe, be a very powerful demonstration of the commitment to move on from the failures of the past.

13.38 Corporate parenting is not satisfied by there being a regular meeting of different States ministries to review child-centred policies. It is a concerted and committed child-centred strategic approach that must inform all relevant States services if the failings that have come to light during the Inquiry are to be avoided in the future. We were struck by the apparent lack of a culture of corporate working across departments and services. This is a matter that requires firm and visible leadership from Ministers, elected members and senior managers. We were, for instance, surprised to hear from the Chief Executive that he had not yet visited Children's Services, despite the fact that he was giving evidence to the Inquiry. If Chief Officers and Ministers do not make it clear by example that they expect services to work together, then services will continue to operate in silos, as seems to us to be the case at present in Jersey. Looked after children need all services to give thought as to how their care and transition into adult life can be supported by their corporate parent, with all of its substantial resources.

13.39 **We recommend** that the responsibilities of the States to all Jersey children should be set out in a Children's Plan, which should include "SMART" (Specific, Measurable, Assignable, Realistic and Time-related) objectives. The Children's Plan should set out how the States will enable all children for whom it is responsible to achieve and fulfil their potential and support them into their adult lives. This means that there must be a strong commitment to thorough care and aftercare for young people who have been looked after. Such plans should encompass all relevant services impacting on children and should cover a period coinciding with the Medium-Term Financial Plan in order that clear financial commitments to support the plan can be made. Progress on the Children's Plan should be reviewed at least annually.

13.40 The Children's Plan should be an easily accessible public document, and a version should be produced that is specifically designed for children to understand. **We recommend** that, in preparing the Children's Plan, consideration is given to how young people can be enabled to remain in their placement for as long as is necessary to make a safe transition into independent living. In this regard, we were impressed by what Action for Children (AfC) had to say in their Phase 3 submission to us. They

recommended adopting “Staying Put” strategies to enable young people to remain in their fostering situation until they reach 21 years of age, and extending this to children in residential settings. Research in England has shown that young people in “Staying Put” projects do better in education and make a more successful transition to independent living.

Recommendation 7: The “Jersey Way”

13.41 Throughout the course of the Inquiry, we heard reference to the “Jersey Way” notwithstanding that there did not seem to be any set definition of the term. On some occasions it was used in a positive way, to describe a strong culture of community and voluntary involvement across the island, and this is something we recognise as a strength of the island, from the many contacts we had with voluntary organisations and individuals who give generously of their time to serve the interests of others. On most occasions, however, the “Jersey Way” was used in a pejorative way, to describe a **perceived** system whereby serious issues are swept under the carpet and people escape being held to account for abuses perpetrated. A Phase 3 witness told us: “*we* [also] *have the impossible situation of the non-separation of powers between the judiciary and political and there is a lot of secrecy, non-transparency and a lack of openness. This brings with it the lack of trust, the fear factor that many have spoken about and contributes greatly to the Jersey Way”.*

It is this strongly held perception by many of those who experienced abuse that will continue to undermine any attempts to move the island forward from the matters into which we have inquired. **We therefore recommend** that open consideration involving the whole community is given to how this negative perception of the “Jersey Way” can be countered on a lasting basis.

13.42 Jersey has a long and proudly held tradition of governance, but that is not to say that steps should not be taken to reflect the modern world in which the island exists. As with many long-established jurisdictions, there can be a resistance to change, which is something that seems to be acknowledged. We are of the opinion that this serious matter cannot be addressed without further consideration being given, in the light of our findings, to recommendations contained in the Clothier and Carswell Reports.

13.43 While these involve constitutional matters, we are firmly of the view that the progress that must be made in relation to future care and safety of children in Jersey will be undermined if they are not dealt with such that all perceptions of there being a negative "Jersey Way" are eradicated once and for all. Achieving this would, in our opinion, provide a very strong visible marker that there was a deep determination in the island to use the conclusion of the Independent Jersey Care Inquiry as a platform to ensure that the island's children and young people will be looked after in a caring and compassionate system that is underpinned by a system of governance in which there is the utmost confidence among all of the island's citizens.

Recommendation 8: Legacy issues

13.44 The most constructive legacy that Jersey can build from its child care history is to fulfil the aspirations of the many citizens, including people who are or have been in the care of the state, political institutions, voluntary sector agencies and professionals, and to ensure that future child care services protect and nurture children, as well as giving them opportunities to heal and to thrive. Jersey also has a notable tradition of embracing, acknowledging and honouring its past, such as the painful period of its Occupation in World War Two. The Panel recommends that Jersey build on this tradition by ensuring that its complex and often unhappy care history is remembered and that the experiences of generations of Jersey children, whose lives and suffering worsened because of failures in the care system, are respected and honoured in decades to come.

13.45 **Four areas of action are recommended**:

a Preserving and making accessible the Inquiry archive.

b Remembering and recognising Jersey's child care history.

c Redeeming the Haut de la Garenne site.

d Care for witnesses after the Inquiry.

Recommendation 8a: Preserving and making accessible the Inquiry archive

13.46 The Inquiry received millions of pages of documents and evidence. Those that were considered most relevant and that have been used during public

hearings and in coming to the findings in this report have been redacted and put into the public domain. The evidence includes detailed accounts and personal experiences of child care in Jersey, which are an important contribution to the record of the island's history. From stories of interaction between occupying troops and residents of children's homes through to accounts of daily struggles of Jersey families, to the background to Operation Rectangle, a vast collection of data held by the Inquiry chronicles the response of Jersey to the needs of its most vulnerable children and sets out how they were affected by state policies and intervention. This material is an important source of social and political history for the people of Jersey and for scholars in those fields.

13.47 Jersey citizens and politicians have properly expressed to the Inquiry their concern that the archive of the Inquiry be preserved for posterity. The Panel agrees with this recommendation, but recognises, as set out in our Protocols, that different categories of material require different archiving and storage solutions.

13.48 **We recommend** that all public-domain material from the Inquiry should remain in the public domain in perpetuity, and that the archive of its documentation should be preserved for Jersey. Material not in the public domain requires a different approach. The privacy of individuals who gave evidence anonymously or in private session must be protected; and extraneous material (for example, that not relevant to the Terms of Reference and not used) must be excluded. The Panel also recognises that provision must be made to future-proof the Inquiry archive so that documents can be accessed and read as technologies develop and the software of the present day becomes redundant (for example, in the way that punchcards, tape and floppy disks create problems for current systems). It is also recognised that better indexing and search facilities will be needed to facilitate access to the materials. Although, as the Inquiry's commissioning body, the States of Jersey has ownership of the Inquiry archive, the sensitivity of some of the material held by the Inquiry (for example, identities of anonymous witnesses, and evidence given in private) is such that it would be imprudent for it simply to be

handed over to the States of Jersey or its representatives, because of the risk of a perception that it may be accessed inappropriately.

13.49 The Inquiry has undertaken some preliminary planning and research for the management of its archive. We recognise the experience available in Jersey through the Jersey Archive and believe that to be a primary source of assistance and a repository for all public-domain material.

13.50 The remaining documentation must be preserved in a secure, neutral venue, with independent oversight. **We recommend** that such material be archived off-island, in facilities provided by one of the international institutions with experience in the retention of Inquiry and sensitive judicial archives, with access and security overseen by an independent third party.

13.51 It has not been possible, because of the need to avoid any perception of improper engagement, for the Inquiry to engage in detailed discussions of archive management with the States of Jersey pending the publication of this report. **We recommend**, therefore, that the Inquiry retain all its documentation under present secure arrangements, until a plan is agreed with the States of Jersey for the permanent security, management and accessibility of the archive. When the Panel, and any advisers it may consult, is satisfied that robust arrangements are in place for the storage and accessibility of all categories of information, the Panel will transfer ownership of its archive.

Recommendation 8b: Remembering and recognising Jersey's child care history

13.52 Jersey has sought to recognise and respond to failings in the States' dealings with children over many decades through the establishment of this Inquiry; through the apology to victims made by the Chief Minister; through the Historic Redress Scheme, which sought to compensate victims and spare them additional harrowing experiences of litigation; and through support for work with former care leavers. We are of the view that remembering the past is one of the best ways to shape a better future. Many of the hundreds of witnesses whose stories the Inquiry heard wanted, more than anything else, an acknowledgement that they had been failed and harmed, as well as the

reassurance that no other child in Jersey would ever have to experience what they had endured.

13.53 **The Panel recommends** that remembrance will be assured, and healing within the island assisted, by the creation of some form of tangible public acknowledgement to the many hundreds of children and young people who have been ill served by the child care system over many decades. The form of this and its execution is for the people of Jersey to decide. The Panel would suggest only that the medium or approach adopted acknowledge the realities of the past and speak to the future aspirations of the island for its looked after children.

Recommendation 8c: Redeeming the Haut de la Garenne site

13.54 In the course of its work, the Panel made five visits to the former Haut de la Garenne (HDLG) Children's Home. The site and some of the original buildings are now used as an outdoor centre. An adjoining building, Aviemore, is used for various child care services.

13.55 Despite current use of some of the HDLG buildings for outdoor/hostel activities, areas of the vast building are in disrepair and provide a poor standard of facility.

13.56 The buildings featured prominently in the evidence heard by the Inquiry. For decades, the site provided institutionalised care for thousands of Jersey children – initially as the Jersey Home for Boys (JHFB), and then, from 1959 to 1986, as HDLG Children's Home, admitting girls as well. Few positive memories emerged from the accounts that the Inquiry received from hundreds of former residents. Many spoke of a physically harsh and abusive regime in which they had experienced little nurture, kindness, encouragement or individualised attention. Some described sexual abuse by staff or older residents. The overwhelming majority had suffered ill effects from abusive experiences or lack of care well into adult life, often impacting significantly on their ability to form and sustain relationships.

13.57 For many former residents, and for other Jersey citizens, the HDLG buildings are a reminder of an unhappy past or shameful history. For other people in

Jersey, HDLG is an unwelcome symbol of the turmoil and trauma of the early stages of Operation Rectangle and the attention brought to the island.

13.58 **The Panel recommends** that the States of Jersey considers negotiating to secure unrestricted ownership of the site and to demolish the HDLG buildings. Given the associations of the site, no States of Jersey services for children or for victims of abuse should be located there in the foreseeable future. The site is a prime site in the island, and is suitable for a range of developments. Should the site be retained for youth/outdoor activity, these opportunities should be provided in a modern facility, with no resemblance to the original buildings.

Recommendation 8d: Care for witnesses after the Inquiry

13.59 From the outset of our work, we recognised how difficult it would be for many people to come forward to tell us of their experiences, and indeed for others to read or hear of these experiences. To that end, the availability of victim support was a priority for us, both through Victim Support Northern Ireland, and through the work of our legal team who were in regular contact with witnesses in advance of their evidence, on the day of their giving evidence, and in the weeks following their evidence. It was, in our view, very important that those whose applications had been approved by the Historic Redress Scheme had funding for independent counselling made available to them. We are aware that victims and survivors often hold on to a hope that, once they have given their evidence to an Inquiry such as ours, painful memories will begin to dissipate and fade. We are, however, conscious that this may not be so for some, and, indeed, the publication of our Report may well re-open memories for some. Accordingly, **we recommend** that arrangements are put in place for ongoing support for all who may feel that they need it in the aftermath of the Inquiry.

Concluding remarks

13.60 Establishing the Independent Jersey Care Inquiry was a significant step for the States of Jersey to have taken on behalf of the people of the island. We have no doubt that there is a general commitment to learn from the past and

to make improvements for the future. We are, however, aware that it is a common criticism of public inquiries across jurisdictions that there is, in the majority of cases, no follow-up to verify what action has been taken in respect of findings and recommendations that have been accepted by those commissioning the report. It is, of course, for the public bodies in Jersey to decide whether and how our recommendations are implemented. We do, however, consider that the recommendations in this Report form the basis of building a better and safer future for all children in Jersey. To that end, it is our view that, from the outset, a mechanism should be established to monitor and verify the implementation of the recommendations. A transparent way of doing this, and one that **we recommend, is that the Panel returns to the island in two years to hear from those providing the services and those receiving them**. We envisage that this would be undertaken in a public forum similar to Phase 3 of the Inquiry. It may be that the Children's Commissioner, when appointed, could invite the Panel, who would report within a very short timescale after hearing from key participants.

APPENDIX 1

Chronology of Significant Events in Jersey Relating to the Inquiry's Terms of Reference

DATE	EVENT
12 February 1935	Loi appliquant à cette Ile certaines des dispositions de l'Acte de Parlement intitulé "Children and Young Persons Act, 1933" formalised arrangements whereby children in Jersey could be sent to approved schools in England and admissions to care. Other provisions of English Act only adopted in 1969.
1940	Loi (1940) sur la Protection de l'enfance regulated foster carers' duties in Jersey.
1 July 1940	Jersey occupied by German forces.
9 May 1945	Liberation Day.
1946	Public Instruction Committee Act 1946 passed.
January 1946	Public Instruction Committee (PIC) inspected Jersey Home for Boys (JHFB) and found living conditions below the expected standard. It recommended a major refurbishment of Home to counteract the "depressing effect" the environment was having on children.
18 January 1946	Medical Officer for Health (MOfH) reported most of children in island, previously malnourished and failing to thrive because of wartime shortages, had recovered to pre-Occupation levels of health.
May 1946	Westaway Crèche found to be overcrowded and understaffed. Eleven children were later sent from the Crèche to South Africa to be adopted there.
November 1946	PIC determined that the Matron of Jersey Home for Girls (JHFG) was unable to carry out her duties in a satisfactory manner and that permanent staff should all be replaced as soon as possible.
18 November 1946	Children and Young Persons Act 1933 amended: Committee vested with parental rights of any young person committed to an institution in the island, till they are aged 18.
1947	Adoption of Children (Jersey) Act passed.
1947	New Superintendent of JHFB, and his wife became Matron.
1947	Sister Henriette Mouton became Sister Superior at Sacré Coeur.
December 1947	PIC became sole authority responsible for care of "deprived children".
1948	Office of Senator created in Jersey – eight senators represented whole island.
April 1948	Insufficient staff available to run JHFG and additional staff to be engaged.
January 1949	MOfH reported overcrowded conditions (91 residents) at JHFB.
1951	Mr and Mrs Walden accepted to care in their "vegetarian guesthouse" at La Preference.

1952	UK Vegetarian Society established La Preference as Vegetarian Children's Home, with the residents fostered by Mrs Walden.
1952	New Superintendent at JHFB.
1953	Public Instruction Committee Act included statutory powers to make payments for maintenance and subsistence of children in care.
1954	Investigation by PIC after a houseparent resigned over excessive use of corporal punishment by a senior member of staff concluded there had been “irregularities and errors of judgement”. The senior staff member resigned and the Houseparent withdrew his resignation.
November 1955	Two nurses resigned from the Westaway Crèche in protest at treatment of children and working conditions, after boys had been placed in isolation for three to four days and nights. PIC determined there was no evidence of cruelty to children.
November 1957	Bailiff advised President of Education Committee that UK Home Office had expressed concern about the lack of a Children's Committee in the island.
January 1958	Education Committee responded to concerns raised by UK Home Office about child care arrangements in Jersey and adopted strategy that led to the creation of a Children's Committee and the appointment of Patricia Thornton as the first Children's Officer (CO) in 1959.
1958	States asked Education Committee to convene a meeting of Committee Presidents, Constables and others convened by President of Education Committee to discuss child care arrangements.
1 March 1958	Members of Education Committee visited East Sussex to examine arrangements for child care and study effects of Children Act 1948 in England.
28 May 1958	Education Committee reported back to States. Memorandum set out need for a CO, who would be employed by Education Committee. Sub-Committee of Education, Children's Committee to be formed to bring together responsibilities for children in need of care previously spread among Public Health, Education and Finance Committees, 12 Parish Constables and Royal Court.
August 1958	Westaway Crèche premises inspected by a member of the Children’s Committee, who determined them to be “totally unsatisfactory”.
February 1959	Patricia Thornton took up post as Jersey's first CO.
September 1959	JHFG closed and merged with JHFB as Haut De La Garenne (HDLG).
1960	Children's Sub-Committee (CS-C) set-up. Led by members of Education Committee and attended by CO and, initially, Superintendent and Matron of HDLG.
11 May 1960	CO annual report to CS-C confirmed that the “supervision of 94 children” included the children at the Vegetarian Children's Home, La Preference.
September 1960	Nicholson Park Family Group Home (FGH) opened.
1961	Colin Tilbrook appointed Superintendent of HDLG.
1961	Education Committee agreed to Colin Tilbrook's suggestion that children at HDLG should have more contact with outside world

	and that visitors to the Home should be encouraged.
18 January 1961	Education Committee discussed allegations of abuse made by a child against a member of HDLG staff, Peter Brooks. Allegations investigated by CO. Police involved. Consequently, Mr Brooks was arrested and subsequently convicted.
October 1961	Colin Tilbrook obtained Committee agreement to build two detention rooms at HDLG, to be “used only … on very rare occasions”, given HDLG role as Jersey’s remand centre.
25 October 1962	CS-C minutes included reference to Jersey's children's homes still being run on disciplinary rules drafted in 1924. Patricia Thornton recommended updating rules.
February 1963	Janet Hughes was approved to foster a child. The assessment involved assessment of the premises alone, which were deemed satisfactory although without indoor plumbing, as “Very few people in Jersey had their own bathroom and hot and cold running water” at the time. Assessment in line with prescribed approach.
1964	Patricia Thornton visited Sacré Coeur and reported that “there were various questions of emotional deprivation” that should be addressed.
7 May 1964	Janet Hughes, previously a foster carer, appointed as Housemother at Clos des Sables, with husband Leslie. One part-time relief worker appointed by Education Committee.
August 1964	After three months spent getting to know children on visits, Janet and Leslie Hughes moved into Clos des Sables with nine children, including their own.
September 1964	Clos des Sables opened as a FGH for up to eight children. Leslie and Janet Hughes worked as houseparents.
November 1964	Home Office Children's Department carried out an Inspection of local services and made positive comments in relation to the “supervision of children in foster homes and Children’s Homes”. Noted under-resourcing of services to be an issue.
March 1965	Houseparents and residents of Nicholson Park moved to Clos de Roncier.
1966	Children's Sub-Committee approved rules for use of detention rooms at HDLG, which permitted a child to be locked up for a continuous period of four days. In practice, children were kept longer in detention by being allowed out for short periods of time.
February 1966	Children from Westaway Crèche moved to HDLG.
1967	Health Insurance (Jersey) Law 1967. Hospitals taken into public ownership. NHS-type service introduced. GP practice became part of insurance scheme.
1968	Patricia Thornton, Children's Officer, suggested that HDLG was not suitable for children with long-term care needs and proposed more reliance on FGHs.
1968	Report to CS-C recorded children at HDLG had spent periods ranging from one night to just under three months in detention.
14 November 1968	Letter from Colin Tilbrook to Patricia Thornton said that Ray Williams (member of staff) at “breaking point”. Referred to his “constant criticism about the numbers of children in each group” and urged Patricia Thornton to review matter and not allow number of children to exceed totals he had set for HDLG.

December 1968	WN279 and WN281 reported to CS-C on opening of new FGH.
January 1969	Children (Jersey) Law passed, imposing duty from 1 January 1970 to register and inspect voluntary homes over which States had previously had no jurisdiction. Education Committee now had duty to give primary consideration to boarding out a child received into care and only place a child in an institution if boarding out not practicable or desirable. Also set out statutory bases for admission of a child into care.
1969	Colin Tilbrook wrote to Patricia Thornton about the “excessive number of children at HDLG”.
1969	CO’s Annual Report for 1968 noted her “gratitude to the voluntary Homes, La Preference and Brig-y-don”. The “statistical analysis” in the report noted children in care in “Voluntary Homes and Hostels” – recorded from 1966 onwards.
July 1969	Houseparents appointed at Norcott Villa FGH.
1970	Home Office Review of HDLG carried out by inspectors Cuffe and Heady. They were critical of the multiple functions the Home fulfilled and raised unspecified concerns about staff attitude to detention rooms.
1970	Children (Boarding Out) (Jersey) Order 1970 came into force. States required to vet and appoint foster parents who would promise to bring child up “as I would a child of my own”.
1970	Major re-organisation of HDLG, reducing the number of pre-school children and increasing the number of secondary school children.
1970	CS-C concerned that detention of children at HDLG pending court appearance might be unlawful.
February 1970	Brig-y-Don (BYD), a former convalescent home, was registered as a voluntary home and started to work closely with Children's Services.
May 1970	Home Office inspection of the Children's Department was critical of departmental organisation and lack of staff development and training.
June 1970	WN279 and WN281 moved with children to new premises for FGH.
June 1970	La Preference was formally registered as a “Voluntary Children's Home” for “20 children” by the Education Committee, under the newly introduced Children (Jersey) Law 1969.
9 October 1970	Morag Jordan appointed as nursery nurse at HDLG.
10 July 1971	Edward “Ted” Paisnel was arrested, detained and subsequently charged for numerous offences by the States of Jersey Police (SOJP).
September 1971	Patricia Thornton, CO, expressed further concern about standard of care offered at Sacré Coeur.
October 1971	Patricia Thornton tendered her resignation as CO to take up a post as “Assistant Director of Social Services (Residential and Support Services)” for the City of Portsmouth from January 1972. Charles Smith appointed as her replacement.

13 December 1971	The Vegetarian Home for Children (La Preference) leadership changed after Mrs Walden retired. Home asked for consideration of an “extra allowance” for the work successor did with younger children and confirmed that “the States do not make a grant to us to help in running La Preference”.
1972	Dr Stephen Carter appointed as first consultant paediatrician in Jersey, succeeding two GP paediatricians.
March 1972	Housemother at Norcott Villa was sacked following adverse reports on “the care and control of the children”.
April 1972	New houseparents appointed at Norcott Villa FGH.
August 1972	Despite 1969 Law requiring that no child should be imprisoned, Education Committee decided that “worst offenders” should be admitted to women's section of prison, provided that CO was present in court when decision was made.
1973	John Rodhouse appointed Director of Education.
1973	Colin Tilbrook ceased to be Superintendent of HDLG.
1973	New Superintendent of HDLG appointed, on departure of Colin Tilbrook. His wife was appointed Matron. She was “shocked at the way HDLG was being run”.
1973	Margaret Holley became Matron of BYD.
March 1974	Superintendent and wife leave HDLG; couple found staff very insular and resistant to the changes they wanted to introduce. He also found a lack of support from Education Committee and low priority given to children's services.
March 1974	New staff from UK appointed Superintendent and Matron of HDLG. They described what they found at HDLG as “almost a workhouse environment” where children were not treated as individuals.
13 March 1974	Application made and approved by CS-C for an increase in “amount paid [by Education Committee] for each child” placed at La Preference.
May 1974	WN279 fell seriously ill. Her role was taken on by an assistant housemother.
September 1974	WN279 returned to duty as Housemother of FGH.
22 November 1974	Janet Hughes on sick leave from Clos des Sables. Leslie Hughes appointed as temporary staff member to cover for her.
November 1974	Education Committee considered allegations of assault made against Gordon Wateridge and determined that, if upheld, he would be dismissed. No report made to SOJP and Mr Wateridge left shortly afterwards, with a positive reference.
January 1975	Keith Barette, a member of the CS-C, prepared a report on HDLG following visit to Home. He found HDLG too large, that the mix of functions was unsatisfactory and that staff turnover had an unsettling effect on children who had already been affected by change.
9 January 1975	Richard Owen, who was working as a chef in Jersey, was recruited by Charles Smith to be a residential child care officer (RCCO) at HDLG. It was not known to Children's Services in Jersey that, nine years previously, he had been convicted in England of unlawful sexual intercourse.
February 1975	Children living at FGH, run by WN279 and WN281, disclosed physical abuse to their teacher, adding to concerns the school

	had about their care in the FGH.
21 February 1975	Janet Hughes returned to work at Clos des Sables after four-month absence when her husband, Leslie, covered for her.
12 March 1975	Following the departure of the experienced Housemother, CO report to CS-C confirmed “concern over the care of children at La Preference” apparently caused by “inexperienced child care staff” and the inability of the “Governing Body ... to recruit trained staff who were vegetarians”.
16 April 1975	CO confirmed that the [new] houseparents at La Preference “had resigned” and the previous houseparents had agreed to return 'on the understanding that additional staff were employed to care for the 20 children resident there’. It was also agreed to “recruit staff locally who need not necessarily be vegetarian”.
November 1975	Morag Jordan promoted to Grade 2 RCCO at HDLG. Four separate smaller units created at HDLG: Aviemore, Baintree, Claymore and Dunluce.
September 1976	Superintendent and Matron resig**n**ed from HDLG, having recommended the Home be closed and replaced by smaller units. This had been resisted by staff. They had put in place rules regarding punishment and detention that were in keeping with standards of the time.
September 1976	Jim Thomson appointed Superintendent of HDLG.
November 1976	Closure of Norcott Villa FGH recommended by CS-C.
1977	Tom McKeon became first Principal of Les Chênes.
1977	Sister Henriette Mouton ceased to be Superior at Sacré Coeur.
January 1977	WN279 retired from FGH and role was taken over by another staff member until all children were relocated.
June 1977	Following the death of the Housemother, Clos de Roncier closed and children sent to other States homes.
August 1977	Last children from FGH run by WN279 and WN281 relocated and FGH closed.
September 1977	Houseparents and residents of Norcott Villa moved to Blanche Pierre FGH on Le Squez estate.
October 1977	Les Chênes became operational and started admitting children.
18 November 1977	The CS-C considered report setting out the need for a “professional fostering” service in Jersey and identified two current La Preference residents (a girl of 14 years and a boy of 13 years) among those who would benefit from such a service.
June 1978	Dr Stephen Carter retired and Dr Clifford Spratt appointed as consultant paediatrician.
October 1978	Merit award scheme introduced at Les Chênes by Tom McKeon.
4 October 1978	Tony Jordan started work at HDLG. Immediately prior to HDLG, he had been selling equipment for yachts in Jersey.
20 November 1978	Review of Tony Jordan’s probationary period. Unspecified areas of work “unsatisfactory” – probationary period extended for three months.
December 1978	Death of a privately fostered infant after being shaken by foster mother. She was sentenced to four years’ imprisonment for manslaughter. The recommendations of the review that followed were not implemented.

December 1979	Houseparents of Norcott Villa separated Housemother remained in post.
March 1980	HDLG's designation as a remand centre was discontinued as Les Chênes was operational, although had not been used as such since late 1977.
April 1980	Norcott Villa Housemother moved to a post at HDLG, and former FGH Norcott Villa, now known as “Le Squez”, taken over by Alan and Jane Maguire. Jane Maguire appointed Housemother. Alan Maguire appointed Housefather on a no-salary basis. Provided with free accommodation and “various allowances”. They were told at interview that “no physical punishment” of children was allowed.
May 1980	John Pilling of Kent County Council prepared a report on HDLG. He was highly critical of the operation of HDLG and concluded that the routine of the Home was focused on maintaining control at the expense of actually meeting children's needs. He thought the system at Les Chênes existed to meet needs of staff, not residents, and strongly deprecated the withdrawal of home leave as a punishment.
March 1981	David Lambert and Elizabeth Wilkinson, DHSS Social Services Inspectorate, issued “Report of the Inspection of Children's Section of the States of Jersey”. Described high incidence of marital breakdown, alcoholism, mental illness, housing and accommodation problems, heavy drinking by young people and high levels of family stress in the island, and considered the organisation, resourcing, policies and performance of Children's Department. One recommendation was the closure of HDLG. Critical of high number of children in care in Jersey and length of time they spent away from home. Education Committee set up working party to consider recommendations made in report.
March 1981	Symposium on child abuse in Jersey organised by Dr Spratt.
1982	David Castledine appointed as Fostering Officer, following recommendation in Lambert and Wilkinson Report, although retained previous caseload as child care officer (CCO). On taking up post, he found systems disorganised and incoherent.
10 March 1982	The CS-C considered a report from the CO, setting out the “occupancy” and relative “costs per child per week” of the different residential units and confirmed that La Preference was by far the most economical – only “boarding out” offered a cheaper “placement” alternative.
16 June 1982	A male RCCO from HDLG was appointed to a new post as Housefather at La Preference.
1 September 1982	The Education Committee considered a report from the CO concerning the “re-organisation of Haut de al Garenne”, which would include creating “two groups” that could each then be moved to “a separate establishment should a decision to close HDLG be made”.
15 September 1982	The Education Committee considered and approved a report from the CO recommending that a different system of funding be put in place for the placements the Committee “bought in” from La Preference. It agreed that the Education Committee would “secure and fund 18 places”.

17 November 1982	The CS-C confirmed its support for new plans for “Residential Care”, which would see the closure of HDLG and reliance on “smaller units”.
25 January 1983	The CS-C continued its discussions about closing HDLG and moving the residents to “two small Children's Homes”– the “role of the Houseparent” was a particular issue that was given consideration.
February 1983	Children at HDLG were re-organised into two groups: Dunluce and Aviemore.
09 February 1983	The CS-C held a “special meeting” to consider a proposed job description for the Houseparent role and guidelines on how a [States run] “small Home” would be run.
June 1983	Staff confronted head of unit about lack of leadership at Dunluce.
July 1983	A new houseparent was appointed by the Vegetarian Society to take over La Preference.
10 August 1983	Charles Smith advised unit leader at Dunluce that CS-C not satisfied he could run a small children's home because of issues around relationships with staff.
10 November 1983	The *Jersey Evening Pos*t reported on concerns expressed by the two voluntary “local homes” at the talk of the closure of HDLG and the opening of “two smaller homes” – one of which might be provided by the National Children's Home charity from the UK.
16 November 1983	The CS-C considered numerous documents and reported setting out the issues of trying to create “two small Children's Homes” and how the current voluntary homes would fit in with those plans.
1984	Complement of additional staff at Clos des Sables increased to three. Houseparents spent less time in FGH.
February 1984	Charles Smith, who had retired from his post, was replaced as CO by Terry Strettle, who was seconded from the UK Social Services Inspectorate.
15 March 1984	The CS-C was notified that the newly appointed head of La Preference had resigned after one month. Management Committee of La Preference said that they no longer wished to operate La Preference as a Children's Home. The Director of Education had agreed to second personnel to run the Home while looking into purchasing it.
23 May 1984	Morag Jordan resigned from HDLG.
June 1984	Education Committee purchased La Preference. It ceased to be an exclusively vegetarian home. Children and staff started moving over from HDLG.
27 June 1984	The CS-C considered proposals in two reports (one by Anton Skinner and one by Jim Cabot) for likely staffing requirements and the transfer of certain children from HDLG to La Preference.
October 1984	Mario Lundy seconded to run HDLG until its closure.
February 1985	Mario Lundy finished role at HDLG.
September 1985	New officer in charge (OIC) of HDLG appointed for few months till HDLG finally closed.
December 1985	Terry Strettle left his post and was replaced as CO by Anton Skinner.

September 1986	Oakwell developed as specialist home for children with disabilities.
4 November 1986	Richard Davenport, in a letter to a family friend of children at Blanche Pierre, dismissed claims that the children were being mistreated there, describing allegations as “quite scurrilous”.
December 1986	Staff and children remaining at HDLG transferred to the newly opened Heathfield.
1987	BYD started offering shared care, with children dividing time between the home and their family setting.
February 1987	Richard Davenport, in a report to the Education Committee described staff at Blanche Pierre as doing a “grand job” and offering “security and love”. In other case reports, he was critical of the care at Blanche Pierre.
23 February 1987	Re-grading request from Janet Maguire at Blanche Pierre – job evaluation request completed.
July 1987	Geoffrey Spencer appointed as Principal Officer at Heathfield.
November 1987	Anton Skinner advised staff that staff member who had admitted sexual contact with a young person connected to Heathfield should not be re-employed to work with children in Jersey. Staff member was allowed to leave Jersey and obtain work in UK.
1988	Mario Lundy became Principal of Les Chênes.
11 February 1988	Marnie Baudains investigated disclosure by a resident of Clos des Sables of sexual abuse by Leslie Hughes, and interviewed her and another child. No further action taken.
August 1988	Janet Hughes on sick leave from Clos des Sables. Leslie Hughes appointed as temporary staff member to cover for her.
11 August 1988	Anton Skinner responded to further letters from family friend of children at Blanche Pierre, refuting claims children are unhappy there and stating they are “extremely happy”.
1989	Phil Dennett began work on a community-based project at Heathfield, designed to avoid unnecessary admissions to care.
February 1989	Janet Hughes returned to work at Clos des Sables after six-month absence when her husband, Leslie, covered for her.
February 1989	SOJP formed a dedicated Child Protection Team (CPT), later to become known as the Family Protection Team (FPT) (in the 1990s) and the Public Protection Unit (PPU) (from 2007). Initially staffed with two specialist officers: DS Adamson and DC Laisney.
20 March 1989	One of children previously interviewed by Marnie Baudains disclosed abuse by Leslie Hughes. Marnie Baudains removed her from Clos des Sables and set in train a joint child protection investigation with SOJP.
23 March 1989	Leslie Hughes arrested in relation to a series of sexual offences against female children in his care at a FGH.
April 1989	Audrey Mills took over running of Clos des Sables.
26 June 1989	Karen O'Hara appointed to staff at Blanche Pierre.
3 July 1989	Susan Doyle appointed to staff at Blanche Pierre.
October 1989	Homeless Young Persons Project (HYPP) opened as a joint venture between Children's Services and Youth Service to provide accommodation for homeless young people aged 16+.
October 1989	Leslie Hughes convicted on five counts of sexual assault against girls resident at Clos des Sables. Subsequently

	sentenced to three years' imprisonment.
10 October 1989	Crown Advocate who prosecuted Leslie Hughes suggested to Anton Skinner that he might wish to review conduct of a staff member to whom complaints of abuse had been made but who had taken no action to protect children. No action was taken. Crown Advocate also suggested introducing a policy that any complaint of abuse "no matter how apparently ill founded", should be investigated.
11 October 1989	Anton Skinner reported in press as saying he would prepare a report into what had happened at Clos des Sables following the conviction of Les Hughes. No review undertaken.
November 1989	Development of a multi-agency Child Protection approach between SOJP and Children's Services. Childline launched in Jersey.
December 1989	John Rodhouse retired as Director of Education and was replaced by Tom McKeon.
December 1989	Clos des Sables FGH closed and residents moved to other homes.
16 February 1990	CCO visited Blanche Pierre. Jane Maguire talked about home being built for them nearby, on States Loan Scheme.
9 March 1990	Chief Probation Officer (CPO) wrote to Anton Skinner, expressing concern over child protection referral where Children's Services disclosed to a family the source of the referral and that the investigation was undertaken by telephone rather than the child being seen.
19 March 1990	Anton Skinner responded to letter from CPO who expressed concern over management of child protection case, explaining "Our inquiries to some extent were therefore guided by an in-depth knowledge and experience which obviated the need for slavish adherence to procedural guidance [that the subject of a child protection referral should be seen]."
20 April 1990	Karen O'Hara witnessed a child being thrown across room – a distance of 10 to 12 feet – by Alan Maguire, at Blanche Pierre. She was concerned that he had been seriously injured. Later in day, Alan Maguire boasted of incident to Sue Doyle. The two women spoke to Audrey Mills about their concerns over the Maguires' mistreatment of the children, and she advised they talk to Dorothy Inglis
24 April 1990	Sue Doyle and Karen O'Hara recounted their concerns to Dorothy Inglis and described incidents of ill treatment of the children they had seen.
25 April 1990	Dorothy Inglis sent five-page statement of concerns raised by Karen O'Hara and Sue Doyle to Anton Skinner and Geoff Spencer. Set out eight specific complaints relating to nine children and concerns about physical punishment, emotional and verbal abuse affecting all children placed at Blanche Pierre.
27 April 1990	Anton Skinner interviewed Sue Doyle and Karen O'Hara and recorded their accounts of extensive abusive practices towards children at Blanche Pierre. He noted their accounts of 19 specific incidents involving seven children and that all children were smacked, threatened and demoralised. Foster child was constantly threatened with being sent away. Children endured long periods in their room or being grounded as punishment.

	Shortage of money for treats for children. Staff discouraged from making relationships with children.
30 April 1990	Date of first interview between Anton Skinner and Jane and Alan Maguire that was recorded on note prepared three months later. The Maguires described abusive practices they operated, including washing mouths with soap and hitting children, but refused to recognise them as inappropriate.
4 May 1990	Staff member at Blanche Pierre became concerned for safety of a resident because of threats made by Alan Maguire. Contacted Geoff Spencer, who advised she alert the resident. The resident ignored warning and returned later to Blanche Pierre, but later fled to a staff member's home, in fear of Alan Maguire. Dorothy Inglis and Geoff Spencer contacted and advised resident should remain with staff member. Discussions later started between Anton Skinner and the Maguires, over their departure.
14 May 1990	A taxi driver contracted to transport some children in care system made inappropriate comments to a child about her abusive experiences. Incident prompted consideration for first-time of vetting drivers used by States to transport children in care.
June 1990	Jane and Alan Maguire left Blanche Pierre. No child protection investigation launched. CCOs not advised immediately of the Maguires' departure. Audrey Mills took over running of Blanche Pierre.
June 1990	Anton Skinner asked Karen O'Hara and Sue Doyle to keep quiet about what happened at Blanche Pierre, as "the island would not be able to cope" with more revelations of abuse in the wake of the Leslie Hughes scandal.
26 July 1990	Iris Le Fevre sent Maguires an effusive letter, drafted by Anton Skinner, thanking them for their "110% commitment" to the children in their care. In evidence to the Inquiry, Anton Skinner described contents as "complete balderdash".
August 1990	A group of Children's Services staff, including Dorothy Inglis and Richard Davenport, were "totally outraged" by the Iris Le Fevre letter to the Maguires and met with Anton Skinner. They told him they were "horrified" that Jane Maguire was being redeployed by Children's Services. He rejected their concerns.
1 August 1990	Jane Maguire took up new role as a family centre officer.
6 August 1990	Anton Skinner produced combined note of meetings held 27/4/90 and later in May with Maguires.
14 November 1990	Anton Skinner asked David Castledine to carry out assessment of Maguires as foster parents of a child at Blanche Pierre, albeit the placement of the child had already been agreed by senior staff. Mr Castledine was not aware or informed of the allegations against the Maguires concerning abuse of children at Blanche Pierre.
18 December 1990	Child resident of Blanche Pierre transferred to foster care of Maguires despite no assessment having been carried out. David Castledine told Inquiry that he felt like he had been presented with a "fait accompli".
1991	First Child Protection Guidelines adopted in Jersey.
1991	Corporal punishment prohibited in UK; Children Act 1989 came into force, accompanied by detailed 10-volume guidelines.

1991	Anton Skinner wrote to the Bailiff, requesting a review of the law on corroboration.
24 March 1991	A resident disclosed to staff member at Heathfield he was having sexual relationship with a male member of staff. Senior staff and SOJP informed and staff member was suspended. Anton Skinner asked the staff member to inform his colleagues at Heathfield of his suspension.
4 April 1991	Anton Skinner sent SOJP note of interviews he had conducted with staff member and complainant during the criminal investigation. The staff member was later allowed to resign with a general reference and enhanced pension.
April 1991	Geoffrey Spencer left Heathfield and was succeeded by Phil Dennett and another member of staff, who began to run the Home jointly.
May 1991	Practice of shared care phased out at BYD.
1992	Patricia Bailhache, who had chaired the CS-C from 1988, suggested it be disbanded as it was achieving little and not providing any real scrutiny. She said it never challenged anything and only made recommendations.
29 May 1992	Child who had been fostered by the Maguires moved to residential care, at request of Maguires.
9 June 1992	St Helier Honorary Police discussed Roger Holland and another rejected candidate at monthly meeting. Vingtenier Holmes said they should be allowed to stand for election and Royal Court could decide whether they were suitable.
1993	David Castledine left post as fostering officer.
1993	In paper for working party on law of corroboration, Marnie Baudains identified a number of difficulties in the prosecution of child abuse cases, arising from the fact that a Centenier, not a lawyer, was responsible for the prosecution up to and including the Magistrates' Court stage. The working party recommended that the role should be undertaken by legally qualified prosecutors.
1993	Social worker who arranged meeting between Jane Maguire and child she fostered said she had never seen such a callous attitude towards a child.
March 1993	Working party, chaired by Sir Philip Bailhache, the then Attorney General (AG), recommended a change in the law on corroboration.
1994	Working party noted that there was no statutory obligation in Jersey to provide services to children; consequently child care services were more vulnerable to financial reductions when savings were required.
1995	Children's Services moved from oversight of Education Committee to Health and Social Services Committee.
1995	Strategic policy review on children and families undertaken.
1995	Residential Homes (General Provisions) Order 1995 introduced a complete prohibition on corporal punishment for children within a residential home.
January 1996	SOJP launched an investigation into the abuse of boys by Mr Jervis-Dykes, a teacher at Victoria College. Mr Jervis-Dykes subsequently pleaded guilty to indecently assaulting a number of pupils and was sentenced to four years' imprisonment.

1996	Child Protection Committee formed. Working Together guidance produced.
1996	Agencies invited to nominate representatives to Jersey Child Protection Committee (JCPC), and chair, Maizel Le Ruez, appointed.
December 1996	Mario Lundy on secondment from Les Chênes overseas.
20 January 1997	Memo from Inspector Faudemer to Superintendent Le Breton about concerns that Centeniers were dropping cases at Police Court by offering no evidence without consultation with SOJP.
19 May 1997	Alan Maguire reported receipt of threatening letter to SOJP. When the sender was interviewed, she disclosed allegations of abuse against Alan Maguire.
14 November 1997	SOJP received neighbour's account of all children at Blanche Pierre seeming terrified, spoke of force feeding, no treats, not allowed to mix with otter children, children shabbily dressed, children hit on palms with “brown stick”, all children physically chastised, deprived of presents at Christmas, shouted at.
1998	Officer from SOJP seconded to work with Children's Services in closer multi-agency approach to child protection.
January 1998	Alan and Jane Maguire were charged with offences relating to physical abuse of children at Blanche Pierre.
28 March 1998	Ian Christmas advised charges against Maguires unsustainable under children's law – charges of assault under common law substituted.
31 March 1998	Maguires pleaded not guilty to all charges.
June 1998	Phil Dennett left Heathfield and became acting Resource Manager for Residential and Respite Services.
June 1998	Graham Jennings, Chief Executive of Health and Social Services (HSS), suspended Jane Maguire pending outcome of Police investigation of Blanche Pierre.
8 June 1998	Maguires appeared at Magistrates’ Court. Magistrate Trott adjourned case for 28 days to determine whether case to answer.
7 July 1998	Magistrate decided prima facie case existed. Maguires’ case sent to Royal Court.
7 July 1998	A later review by SOJP officers would conclude that “No system of care” put in place for vulnerable witnesses. Ineffectual screening and sound arrangements made stressful conditions. “Most concerning of all … the Prosecution Advocate, Mr Christmas, who was present in court played no part in proceedings.” Defence advocates allowed “to savage people”. SOJP reviewers considered prosecution did not challenge or test evidence of defence witnesses.
November 1998	Crown Advocate Binnington provided a detailed analysis of the evidence about the Maguire case and wrote: “I have reached the conclusion that it would not be in the public interest for this prosecution to continue further. I reach this conclusion on a review of the evidence.” (He appeared to mean “evidential test”, rather than public interest, according to Mr Birt.)
November 1998	In wake of abandonment of Maguire prosecution, Graham Jennings asked Dylan Southern to produce a report on the allegations of abuse at Blanche Pierre.

1999	Marnie Baudains Manager of Children and Adult Services. Phil Dennett appointed Service Manager, Children's Services.
January 1999	Anton Skinner provided written statement to Dylan Southern on his role and actions in the Maguire case; he identified what he considered to be the different circumstances between 1990 and 1998.
January 1999	Sharp report concluded that if the correct child protection procedures had been followed by Victoria College it was most likely that Mr Jervis Dykes would have been suspended, and perhaps arrested, in 1992.
1999	Youth Panel appointed to sit with magistrate. Panellists appointed for nine years – one third retiring every three years.
29 January 1999	In interview with Dylan Southern, Jane Maguire asserted she was never under any pressure while at Blanche Pierre. Claims she retired from Blanche Pierre because of change of child care policy and moved to care for children in community.
23 February 1999	Report to Graham Jennings by Dylan Southern concluded Jane Maguire was “unfit and incapable” of acting in interests of vulnerable children, was capable of physical and psychological cruelty to children and unfit to work with any vulnerable client group; recommended she be dismissed.
23 February 1999	Dylan Southern wrote to Graham Jennings, recommending that Anton Skinner's conduct with regard to the Maguires in 1990 be investigated. He received no response.
22 April 1999	Disciplinary hearing recommended the immediate dismissal of Jane Maguire.
23 April 1999	Letter from Graham Jennings, Chief Executive, to Jane Maguire with conclusions of disciplinary panel and advising Panel would recommend her dismissal to committee; Jane Maguire resigned in advance of Panel convening.
26 June 1999	Maguires left Jersey for France.
August 1999	Adolescent Fostering Research Project report was critical of the under-resourcing of fostering service, the lack of training for foster carers and the absence of a fostering panel to approve foster carers and of a placement panel to ensure suitable matching of carers and children and monitoring of their progress. It recommended increased support and training for foster carers, fostering and placement panels to be created and independence training be offered to 15-year-olds in the care system and suitable supported lodgings be made available to them.
23 September 1999	Advice from Law Officers’ Department (LOD) that insufficient evidence for warrant for Alan Maguire following new complaint from former Blanche Pierre resident of sexual abuse, but Alan Maguire placed on “Warnings List” to be interviewed if he returned to Jersey.
October 1999	Three team managers – Tony Le Sueur, Sarah Brace and Sue Richardson – appointed in Children's Services.
November 1999	“Working Together to Safeguard Children”, Jersey version, produced by JCPC.
November 1999	A new manager of La Preference appointed.
November 1999	AG decided not to proceed with prosecution of the Maguires,

	following discussion of the case at a meeting involving Crown Advocate Binnington, Mr Christmas, Marnie Baudains from Children's Services and two police officers.
2000	Revised child protection guidance issued.
2000	HYPP became St Mark's adolescent centre, providing accommodation for homeless persons aged 16 or over.
2000	Kevin Mansell appointed Principal of Les Chênes.
2000	Graham Power appointed Chief Officer, SOJP.
February 2000	William Bailhache QC appointed AG.
December 2000	JCPC multi-agency child protection manual published.
15 August 2001	Exchanges between Magistrate Ian Le Marquand, the Director of Education and the Board of Governors concerning number of young people being sent to Les Chênes by the Court and increasing difficulties in the facility.
November 2001	Tony Watton, who had been charged with offences against children, committed suicide.
2002	"Review of Principles, Practice and Procedures at Les Chênes Residential School" by Dr Kathie Bull published.
2002	JCPC establishes post of multi-agency child protection trainer.
2002	Children (Jersey) Law 2002 passed. The threshold for state intervention became one of risk of "significant harm" to the child. Children's Services responsible for looked after children up to age 25.
2002	Leaving Care team introduced to support 16-year-olds leaving care.
February 2002	Tony Le Sueur appointed manager of the Fostering and Adoption Team. He later told the Inquiry that he was astonished that the recommendations of Dr Kathie Bull, for increased investment in foster care and development of professional fostering, were not implemented.
November 2002	Maizel Le Ruez relinquished chair of JCPC and Iris Le Fevre took over.
December 2002	"Review of Principles, Practices and Provision for Young People with Emotional and Behavioural Difficulties and Disorders in the island of Jersey" Report by Dr Kathie Bull published.
2003	Report on "Housing Issues Affecting Children in Care and Children in Need" produced, saying more co-operation needed between Housing and Children's Services, particularly in relation to supporting children leaving the care system.
2003	Leonard (Lenny) Harper appointed Deputy Chief Officer, SOJP.
July 2003	Publication of Report "Hardship Experienced by Children and Young People in Jersey", highlighting the impact of inadequate and costly housing and the high cost of living in Jersey along with the large number of lodgings unsuited for family life and rents that accounted for between 50 and 70% of income.
July 2003	DC Brian Carter of SOJP produced report concerning allegations, made by residents at Les Chênes, of abuse by staff. No action taken, following advice from legal adviser.
August 2003	Police called to Les Chênes following an incident where two residents defied a member of staff and locked themselves in a room.
August 2003	Report by Madeleine Davis following inspection of Les Chênes

	after two residents of Les Chênes disclosed that a staff member supplied them with drugs. Report criticised “inappropriate and legally dubious methods of managing pupils”.
November 2003	Les Chênes became Greenfields and was designated a remand centre. Responsibility for Greenfields moved from Director of Education to Health and Social Services Department (HSSD) and responsibility was transferred from Education Committee. Joe Kennedy appointed manager; introduced “Grand Prix” system at Greenfields, based on an incentive system operating in prisons.
2004	Children's Executive established.
2004	Two self-contained flats at Aviemore unit became part of the “Lifelong Special Needs Service”.
2004	Margaret Holley retired from BYD.
2004	Board of Visitors formed for Greenfields, replacing former system of Governors.
2004	Children's Executive Board formed: responsible to the Corporate Parent, which consisted of President/Minister of Health and Social Services, Minister of Education and Minister of Home Affairs.
2004	Brian Carter of SOJP investigated further allegations relating to abuse in care settings. AG concluded the case could not be prosecuted at present.
2005	Ministerial system of government replaced committee system in States of Jersey.
2005	Jean Andrews appointed as independent reviewing officer to chair case conferences.
2005	Children (Jersey) Law 2002 came into force.
2005	Meeting arranged between Joe Kennedy and Kevin Parr-Burman to deal with “litany of concerns” about management of Heathfield and failings of establishment.
2005	Alison Fossey joined SOJP Child Protection Unit as Detective Sergeant.
December 2005	Thomas Hamon pleaded guilty to charges of sexual abuse.
January 2006	DC Carter discussed with DI Hewlett whether there might be a large-scale historic problem of abuse in relation to care institutions in Jersey.
8 March 2006	Bridget Shaw, Force Legal Adviser, wrote email to Alison Fossey, advising that the AG had issued guidance that cases of child neglect/abuse should not go to a Parish Hall Enquiry (PHE). This led to new guidance, and PHE virtually ceased to be used for such cases.
8 April 2006	DI Hewlett and DC Carter produce a scoping report on the need to investigate historic care institutions in Jersey; report submitted to DCI Bonjour, who said he discussed it with his senior manager and considered it a “fishing expedition” and so did not pursue matters.
23 May 2006	Bridget Shaw passed on concerns of Alison Fossey to the Solicitor General (SG) and raised her own concerns that Children’s Services were waiting for the Police to act in some cases. She noted that Children’s Services did not appear to understand that they could take civil proceedings in which the standard of proof was lower than that in criminal proceedings.

	Meetings were held with senior staff of Children's Services but SOJP felt matters did not improve.
September 2006	New Greenfields Centre opened and Simon Bellwood appointed to run it.
November 2006	New secure facility opened at Greenfields.
January 2007	Simon Bellwood suspended from his post as manager of Greenfields.
January 2007	Review of policies and procedures at Greenfields carried out by Linda Dodds, in wake of complaints raised by Simon Bellwood.
January 2007	FPT was renamed PPU to reflect the fact that the victims of sex offences were not exclusively children or family members.
June 2007	Senator Syvret, Minister for Health and Social Services, raised concerns following publication of a serious case review (SCR) into the case of a child who had been subjected to sexual abuse. Council of Ministers responded with three-point strategy: departments to liaise more closely, Andrew Williamson would be appointed to conduct a review and agreement; in due course there would be a public inquiry.
22 June 2007	Laurence O'Donnell of LOD suggested to senior police officers, including Mr Harper, that it would be appropriate for SOJP to launch an investigation into whether there had been systematic abuse in the Sea Cadets organisation over the past 20 years.
1 July 2007	New investigation designated, with title “Operation Rectangle”.
July 2007	DCO Harper met with DI Hewlett and DC Carter to discuss their report.
25 July 2007	A meeting of the Corporate Management Board and a meeting of the Child Protection Committee took place at the same time. At both meetings, a vote of no confidence in Senator Syvret was discussed and in each case the SOJP officer present withdrew.
27 July 2007	Six of ten Council Ministers wrote a letter to Chief Minister Frank Walker, calling for Senator Syvret to be dismissed as a Minister.
August 2007	New Minister for Health and Social Services, Ben Shenton, invited Andrew Williamson to carry out a review of Child Protection practice.
1 October 2007	Scope of Operation Rectangle set out as including Sea Cadets and HDLG, but not confined to these areas. Impetus for operation had come from series of cases such as Every case, link between a suspect and a retired DCI, the Victoria College investigations, an SCR regarding a child victim of abuse, and public perception that child abuse had been covered up to protect public figures. Mr Harper did not think there was a paedophile ring on the island, but thought there was an endemic problem of abuse that was tolerated and sustained by the inter-connectedness of people and systems in Jersey.
15 November 2007	Bridget Shaw sent letter of concern about Children's Services to AG. She suggested that decisions about risk were being made on basis of whether Children’s Services had suitable accommodation for the child, rather than on whether the child was at risk of harm at home.
16 November 2007	Senator Syvret met with SOJP and supplied “valuable information” about the inquiries he was making about abuse in care system and organisations in Jersey, and was made aware of Operation Rectangle. SOJP made aware of his invitation to

	BBC to make a documentary on child abuse and so decide to make Operation Rectangle's existence public.
21 November 2007	Mr Harper briefed Chief Minister and Chief Executive on press release on Operation Rectangle to be issued next day. His impression was they did not want investigation as it would be bad publicity for the island. They denied this was the case. SOJP press release pre-empted by Senator Syvret, who issued his own release.
22 November 2007	SOJP issued press release about existence of Operation Rectangle.
2008	Children's Executive reported that the full reform programme proposed seven years earlier by Kathie Bull could not be resourced.
2008	Independent Board of Visitors for children's homes established.
January 2008	June Thoburn took up role as chair of JCPC.
7 January 2008	South Yorkshire Police commenced an investigation into the conduct of Mr Bonjour and Mr Pearson, at request of Mr Harper, over alleged failures to pursue allegations of historic abuse.
7 January 2008	AG consulted by Mr Harper and given details of the number of victims and suspects who had been identified in Operation Rectangle. AG realised that LOD would need independent prosecutors, due to scale of the investigation, and to avoid conflicts of interest. Crown Advocate Baker, of Baker Platt, instructed to prosecute the Operation Rectangle cases.
24 February 2008	SOJP press statement that “the partial remains of what is believed to have been a child” had been found at HDLG site. Further forensic investigation concluded the fragment was not bone.
26 February 2008	Bill Ogley, States of Jersey Chief Executive, suggested no more information should be released about investigation until it had concluded and suggested a press conference with him, AG and Graham Power to explain that further media speculation could jeopardise prosecution. Mr Power thought such a move could be perceived as collusive.
2 March 2008	AG advised Council of Ministers to cease public comment and arguments on Operation Rectangle, as it could impact on prosecutions.
27 March 2008	Meeting of Council of Ministers agreed to set up public inquiry once any criminal proceedings had concluded.
29 March 2008	Forensic services advised SOJP that fragment found at HDLG was not bone. SOJP officer thanked them for their “fantastic explanation that really clarified things”. Conclusion was confirmed in an email two days later.
31 March 2008	BBC Panorama broadcasted “Island of Secrets”.
31 March 2008	Chief Minister Frank Walker and his wife visited the scene of the police operations at HDLG. DCO Harper told them that new forensic evidence indicated that no murders had taken place.
April 2008	AG advised Graham Power that investigations should be carried out by an external force into any suggestion of cover-up of historic abuse.
April 2008	Graham Power sought advice on dealing with Senator Syvret's allegations of cover-up from SG, who suggested he consult Advocate MacRae, then in private practice. Advocate McCrae

	reviewed prosecution decisions in relation to Victoria College, Maguires and a sample of other cases, with advice from independent UK counsel, and concluded decisions were acceptable, though more prosecutions could have been considered in relation to Victoria College allegations.
April 2008	Frank Walker discussed with Home Affairs minister Wendy Kinnard fact that no announcement had been made by Mr Harper that no murders had taken place at HDLG. They decided they would not interfere and would let matters run their course.
18 April 2008	SOJP press statement in respect of the fragment found at HDLG in February 2008. Said it was not possible to date the item but it was unlikely that a formal homicide investigation would be instigated in relation to the item alone. However, the site "must remain the scene of a possible homicide" until such time as the excavations were complete.
02 May 2008	Mr Harper sent email to Mr Walker, Mr Ogley and Ms Kinnard. He said that, in the previous week, children's milk teeth and a number of bone fragments had been recovered at HDLG. Initial forensic examination indicated that the child died no earlier than the 1950s.
9 May 2008	The Bailiff, Sir Philip Bailhache, said, in his Liberation Day speech: "all child abuse, wherever it happens, is scandalous, but it is the unjustified and remorseless denigration of Jersey and her people that is the real scandal".
13 May 2008	AG met with Mr Power and Mr Harper and advised that the way that the investigation was being managed in the press was a major cause for concern. It was liable to impact on the administration of criminal justice.
May 2008	Wendy Kinnard meeting with Chief Minister and Chief Executive. Her recollection was that Mr Ogley wanted Mr Harper removed and, when Mr Power declined, Mr Ogley questioned his position. Mr Power became convinced sections of Jersey establishment wanted investigation halted, particularly focus on people such as Mario Lundy. Mr Walker argued this was not the case and identified steps he took to resource inquiry and protect its independence.
June 2008	Andrew Williamson's Report "Children Protection in Jersey" is published. Report covered future strategic direction of child protection, and structure and provision of residential care. Recommendations included greater integration of services, and development of a Children and Young Persons' Plan.
June 2008	Two members of staff reported an assault by the manager of Heathfield, Kevin Parr-Burman, on a vulnerable resident, prompting an SOJP investigation. LOD determined conviction unlikely and recommended disciplinary investigation. HSSD managers decided no disciplinary process needed.
June 2008	John Edmonds joined the LOD as Head of the Serious Crime Section.
24 June 2008	WN279 and WN281 arrested. Mr Harper wanted them charged immediately. Centenier would not do so, in light of advice from legal adviser that, as standard practice, the suspects be questioned before charge. After suspects were released, Mr Harper issued a press statement critical of the LOD.

31 July 2008	Mr Harper stated, in interview with BBC, that remains of at least five children had been found at HDLG site. SOJP later said there was no evidence to support this statement.
7 August 2008	Mr Harper retired from SOJP. He was not offered possibility of remaining to conclude Operation Rectangle, as Mr Power opposed this, wanting a fresh set of eyes, and Mr Harper was said not to have experience necessary to meet Association of Chief Police Officers (ACPO) standard for a contracted Senior Investigating Officer (SIO).
8 August 2008	David Warcup took over as Deputy Chief Officer, SOJP.
15 August 2008	Mr Warcup asked the Metropolitan Police Service (MPS) to carry out a review of Operation Rectangle to identify matters that needed improvement and tasks that should be undertaken. He was also concerned Mr Power was not responding to concerns being raised about the investigation, including personal media briefings still being given by his predecessor, Mr Harper.
September 2008	Michael Gradwell joined SOJP on secondment from Lancashire Constabulary, and took up SIO role.
1 October 2008	Media reports appeared on the intention of the lawyers representing Gordon Wateridge to argue that press reporting of Operation Rectangle had made it impossible for Mr Wateridge to have a fair trial. SOJP recognised the need to set the record straight about unfounded claims made by Mr Harper about findings in the investigation.
18 October 2008	Senator Kinnard met Deputy Minister Andrew Lewis at her home. She remembered, and her husband noted, she was told of steps being considered to remove or discipline Mr Power. Mr Lewis denied he knew of such steps until 12 November.
20 October 2008	Ms Kinnard resigned as Minister for Home Affairs.
November 2008	Howard League for Penal Reform, who had been invited by Senator Syvret to review youth custodial provision in Jersey, published its report. Report was critical of the “Grand Prix” System at Greenfields, saying it was “predicated on … using isolation and deprivation as a means of control”, with potential to deprive children of light, heat, association and comfort for extended periods and highlighting the potentially abusive nature of such treatment and the high risks of using it with a vulnerable population of children, many of whom would have mental health needs.
November 2008	South Yorkshire Police Report concludes André Bonjour should not have left decision-making in respect of investigation of historic abuse cases to more junior officers and should have been more proactive in relation to the report of officers Carter and Hewlett. They recommended internal disciplinary measures. Mr Bonjour disagreed with conclusions.
November 2008	John Edmonds of LOD advised AG that, on basis of South Yorkshire Police Report, “I am not satisfied that we could ever prove to the criminal standard that Andre Bonjour had sat on the {scoping] report … it is probably a fairly typical example of the police deciding for a combination of reasons not to grasp a potentially painful nettle.”

November 2008	Bill Ogley, States of Jersey Chief Executive, took legal advice on process for dismissal of Chief Officer, SOJP.
November 2008	Mr Le Cocq QC, SG, advised that the Ministers did have the power to suspend the Chief Officer while that Officer was absent from the island, and said: “Whether it would be wise to do so is, of course, a different question, the answer to which will depend on the content of the [Metropolitan Police] report.” He also advised that Mr Power should be shown that report and invited to comment on the basis that the Minister regarded it as serious and was considering suspension.
10 November 2008	Interim Report of MPS received by Mr Warcup. MPS had not been able to complete report, as they had yet to interview Mr Harper.
10 November 2008	Bill Ogley received letter from David Warcup in which he put forward extensive criticism of the management of Operation Rectangle, which views he said were supported by the interim MPS report. He did not provide Mr Ogley with the interim report.
11 November 2008	SG advised on content of suspension letter and reiterated the need for sufficient additional objective evidence if it were to be used, if the full MPS report was not available.
11 November 2008	AG advised that suspension of Graham Power should be considered only once the full MPS report had been received and there had been time for it to be fully considered.
11 November 2008	Briefing meeting for politicians about following day's press conference. Meeting was followed by another meeting attended by AG, Mr Ogley, Mr Walker and Mr Lewis, where it appeared to AG that decision had been already taken to suspend Mr Power. Mr Ogley thought the meeting had been to take the final decision and work out logistics of suspending Mr Power.
11 November 2008	Mr Power advised Minister and Mr Ogley wanted to meet with him next day, to discuss concerns about Operation Rectangle arising from MPS review.
12 November 2008	Press conference at which details of findings at HDLG were clarified.
12 November 2008	Mr Power was suspended. Mr Ogley said he was given a letter of suspension and offered an hour to consider matters. Mr Power said he was given an hour to “consider his position” and was implicitly being offered the chance to resign. A later independent reviewed determined that the decision to suspend was procedurally flawed.
20 November 2008	Application on abuse of process in Wateridge case rejected, as judge considered that the 12 November press conference put the record straight about the findings at HDLG. Wateridge was subsequently convicted.
10 December 2008	Mr Lewis took part in an “in camera” (private) debate in the States concerning the suspension of Mr Power. He told States members that he had been astounded by the MPS interim Report's criticisms. He subsequently said to the Inquiry that he had meant the letter of Mr Warcup, not the MPS report.
2009	June Thoburn relinquished chair of JCPC and Mike Taylor appointed.
2009	Residential family centre opened at La Chasse, providing bedsits and flats for young mothers and children.

2009	Williamson implementation plan published. Recommendations included closure of Heathfield. Andrew Williamson was appointed to an interim role in HSSD to oversee implementation.
2009	Brecon Report produced. Recommendations included the need for semi-independent living provision for young people before they left care.
2009	The White House opened for specialist therapeutic residential care.
2009	Guidance on decision-making in care admissions produced "Children's Service Placement Process".
June 2009	Eden House opened to provide respite care for children and young people on autistic spectrum.
June 2009	Deputy Ann Pryke appointed Minister for Health and Social Services.
9 July 2009	Morag and Tony Jordan interviewed in UK. Denied all allegations. Police assessment was that both "lied during their interviews".
1 July 2009	Breckon Report highlighted low morale in Social Services, poor standards of service and resources misdirected to management rather than to frontline staff, and also drew attention to growing demand for Child and Adolescent Mental Health Service and strain that it was placing on service.
27 July 2009	Health and Social Services and Housing Scrutiny Report on the Williamson Report recommendations.
August 2009	BYD ceased to function as voluntary child care home and was refurbished as a States of Jersey home, accommodating children previously at Heathfield, providing placements for up to six children aged 10–16 and a supported living programme.
23 September 2009	AG decided there was "insufficient evidence to prosecute the Maguires" on sexual abuse charges.
November 2009	William Bailhache QC ceased to be AG and became Deputy Bailiff in Jersey.
26 November 2010	Jordan trial at Royal Court Jersey: Morag Jordan found guilty of eight counts of assault in respect of four children. Tony Jordan found guilty of eight counts of assault in respect of two children. Both ultimately sentenced to nine months' imprisonment.
6 December 2010	Formal apology by Chief Minister to all who suffered abuse in Jersey's care system.
December 2010	Operation Rectangle formally ceased.
2011	Phil Dennett became Director of Children's Services.
January 2011	Report by Sean Pontin on "Specialist Foster Care in Jersey" noted that children who would be fostered in other jurisdictions remained in residential care in Jersey because the service could not attract people to care for children who had serious emotional needs, or for older children. He advocated a specialist fostering service to attract new people and tap into other parts of the community.
March 2011	Ulvik House Children's Home opened, for two young people with specific needs.
June 2011	Remaining residents of Heathfield moved to newly opened BYD, now run by the States of Jersey.

2012	Richard Jouault appointed Managing Director of Child and Social Services, although having no social work experience.
2012	Action for Children (AfC) undertook review of services in Jersey, for children with complex and additional needs. Review was critical of lack of clarity about joint working impacting on children and families, lack of capacity for long-term interventions, the lack of safeguarding guidelines for children with disabilities, difficulties in determining thresholds created by absence of child in need legislation. Recommendations included a more personalised, outcome-focused approach to children and families, more personalised and early interventions for children with complex needs, reform of the disability team and increased partnership with voluntary sector.
2012	Corroboration rule abolished in Jersey by the Criminal Justice (Miscellaneous Provisions) (No.3) Law 2012.
2012	Appointment of civilian child protection case conference liaison officer to attend in place of a police officer at child protection case conferences.
2012	Report of Scottish Care Inspectorate, “Inspection of Services for Looked After Children”, identified that the views of young people in residential care were ignored. Rules were emphasised rather than positive aspects of care.
July 2012	Second report by Sean Pontin on the need for a specialist foster care service.
July 2012	Proposal for setting up Multi-Agency Safeguarding Hub (MASH) to enhance joint working on child protection.
September 2012	Residents and staff of Ulvik House moved to Casa Mia.
October 2012	La Preference closed and residents transferred to Field View, which provided independent living facilities.
January 2013	St Mark’s Hostel deemed no longer fit for purpose, and residents relocated to Strathmore.
2013	Placement and Resource Panel established to consider requests for placement.
2013	Glenys Johnson appointed as Independent Chair of the Safeguarding Children and Adults Partnership Boards.
April 2013	The White House closed.
January 2014	The White House re-opened, with three residents.
April 2014	Jo Olsson appointed interim Director of Children's Services.
3 April 2014	Preliminary Hearing of Independent Jersey Care Inquiry.
June 2014	Scrutiny Panel Review of CAMHS published.
June 2014	Senator Andrew Green became Minister for Health and Social Services in place of Deputy Ann Pryke.
22 July 2014	Opening hearing of Independent Jersey Care Inquiry.
October 2014	Seaview Flat opened as a facility for children whose foster placements had broken down.
July 2015	SCR published about events in The White House critical of the ethos of “containment” adopted by staff, the absence of structure to the days and the absence of a systematic therapeutic approach.
August 2015	Mary Varley's “damning” audit of child care practice identified major deficiencies in basic social work skills.

September 2015	Jo Olsson's appointment as Interim Director of Social Services ended. When she left island, she still had concerns about safety of services for children.
September 2015	Susan Devlin took up post as Managing Director, Community and Social Services.
March 2016	Appointment of permanent Director of Children's Services – fifth post- holder in under five years.
22 June 2016	Final submissions to Independent Jersey Care Inquiry concluded.
September 2016	Appointee to Director of Children's Services resigned post and Jersey was faced with recruiting its sixth Director of Children's Services in five years.

APPENDIX 2

Histories of People who Experienced Care in Jersey

Introduction

1. Summarised below are some of the accounts considered by the Inquiry given by those who were in the care system in Jersey. Their experiences range over many decades. Some details have been obscured (for example, exact dates of residence in an establishment or placement) to protect the privacy of individuals whose evidence was given anonymously.

2. Included are all the accounts given, read or highlighted during the 144 days on which the Panel heard evidence. Some of these accounts were provided originally to the States of Jersey Police (SOJP) or to the Historic Redress Scheme. We have listed only the accounts of former residents themselves, with two exceptions: where evidence was provided on behalf of a former resident who had since died, and where evidence was provided by the parent of a young person with disabilities.

3. The Panel was also assisted by the evidence of persons who, as young people, lived in or close to care establishments with their families. These accounts are not included here, as the persons concerned did not experience the institution as a young person in the care system.

4. The Panel also received evidence from visitors to establishments, neighbours, families and care staff, which sometimes included references to the people listed below. While that evidence has been valuable in understanding the culture and practices in establishments and in foster care, the histories recounted below have been drawn exclusively from the accounts of former residents. The exceptions to this are in circumstances where former residents have died and, in the case of a young person with a disability, when the account is taken from evidence provided by family members.

5. Our brief summaries of each account in this Appendix are not intended to encompass the extent and nature of the histories recounted and the

experiences lived by many young people in residential and foster care in Jersey over many decades.

6. The material runs to over 50 pages, and many of the details, even in summary form, are distressing. We urge everyone reading this Appendix to proceed cautiously and to pause if they are affected by the volume or nature of the histories that they encounter. Details of organisations offering support are available on the Inquiry website at: http://www.jerseycareinquiry.org/giving-evidence/witness-support-information.

Witness name or number	Evidence	Period	Care settings	Story	Day
237	Read	1930s–1950s	Sacré Coeur	He has no complaints about his treatment at Sacré Coeur and describes most of the nuns positively. He recalls one nun smacking and pushing boys and hitting them with a broom handle. He recollects children being smacked for bedwetting and children being locked in cupboard under stairs for misbehaviour. He says he had plenty of food. He did chores but this was not oppressive and he was unaware of any abuse while he was there.	65
Jean Neil	In person	1930s–40s	Westaway Crèche, JHFG	Generally well looked after at Westaway. Describes a harsh regime at JHFG, clean clothes only once a week, severe and humiliating physical punishments for minor infringements including being beaten with nettles for bedwetting and being dunked in ice-cold water. Alleges she was sexually assaulted while drugged and molested by a visiting PE teacher. Spent two weeks in isolation with little food after absconding with group of peers. Malnourishment from years in care damaged her health and prevented her following her chosen career.	19
Gifford Aubin	In person	1940s	JHFB	Describes a lack of staff and a harsh, punitive regime. Senior boys bullied younger and vulnerable boys, including applying electric shocks to legs. Hand still has scar of injury by older boys. Saw other children having mouths washed with soap. Only learned to read and tell time in later life. Positive recollections of occupying soldiers who brought toys at Christmas and provided extra bread for the boys.	8
Violet Renouf	In person	1940s		Was fed bread and water on Christmas Day for losing penny for church collection. Describes punitive regime, including spending long period in isolation room. Had fat from frying pan tipped over her. Despite passing 11-plus exams, was not allowed to progress to grammar school. Girls seen talking with boys were subjected to intimate physical examination. "*There was never any love; never any affection*."	8
John Doublard	In person	1940s	JHFB, BYD	JHFB – Lack of staff. Senior boys bullied younger and vulnerable boys including applying electric shocks to legs and genitals. Had a positive experience of care at BYD.	22

260	Read	1940s	JHFB	Describes a strict disciplinary setting, with some physical punishments and work chores. Had complaints about punishments. Was critical of brutal bullying by older boy, which included his arm being broken and being stabbed. He was taken to hospital for first injury but warned not to say how it had occurred. For the more serious injury he received no treatment other than from staff at the Home. A member of staff attempted unsuccessfully to assault him sexually and he was aware of another boy being distressed by approaches from this person.	16
482	Read	1940s	Westaway Crèche, Foster care, BYD, JHFG	In foster care, was made to sleep on chamber pot for the night. Was well cared for at BYD. At JHFG, was given spade with her name on it and told she would be hit with it for bedwetting.	139
258	Read	1940s–1950s	Westaway Crèche, JHFG, JHFB	Was in care for around 13 years. Life was quite harsh at JHFB but he and other boys accepted it. Frequent physical punishment, often meted out by older boys who helped keep order because of staff shortages. Boys' punishments were particularly cruel. Witness describes being hit by staff with a fork, having a broom thrown at him like a javelin, boys being hit on hand with thick end of a billiard cue and having mouth scrubbed with soap. A lot of time was spent undertaking chores in the Home.	16
Winifred Lockhart	In person	1940s–1950s	Westaway Crèche, JHFG, Foster care, JHFB	Mistreated in foster care. Subject to physical and emotional abuse. Made to sleep in shed because of bedwetting. Was not given any liquids and had to collect rainwater in a can to drink. Describes telling children's officers of abuse and neglect but was not removed until she had to be admitted to hospital for an untreated condition. Initial experience at JHFG was positive due to influence of a kindly Head of Home. By the time she left, the regime was punitive and abusive. Things improved slightly when Miss Thornton appointed. When moved to JHFB, was aware of boys being abused. Regime was cruel and based on fear and corporal punishment. Made repeated disclosures of abuse including to teacher, children's officer and medical staff but no-one believed her.	11

Malcolm Carver	In person	1940s–1950s	JHFB	Only three members of staff to cover whole institution. Bullying by older boys was unchecked. Boys went barefoot most of time. He describes strong camaraderie among the boys. He was unaware of detention rooms.	9
156	Read	1940s–1950s	Sacré Coeur, JHFB	Describes nuns as cruel and environment of Sacré Coeur as harsh. Frequent physical punishments and also locked in “cellar-like room”. Nuns terrified children with stories of hell and torment. JHFB regime was harsh. Physical punishments meted out regularly by older boys and by masters included beating with leather strap, sometimes on bare skin, and being hit on head with bunch of keys. JHFB improved when a new superintendent arrived in 1950s. Physical punishments reduced – only punished by superintendent, underwear provided for first time and food improved. Witness feels his confidence was damaged for life by treatment in care system.	16
190	Read	1940s–1950s	JHFB	In late 1940s, regime was tolerable as superintendent kindly, but “things changed dramatically” when he left. Replacement seemed to take pleasure in inflicting vicious physical punishments, which witness remembers caused gaping wounds, welts, bleeding and severe bruising. No medical treatment for wounds caused by punishments. Recalls being severely beaten for refusing to eat rotted lettuce at mealtime. Describes group of eight boys who absconded telling police about ill treatment at JHFB, but nothing was done. Former resident attempted to assault him sexually. Described lifelong consequences of separation from siblings and family and of maltreatment.	16
208	Read	1940s–1950s	JHFG	Describes being taken from bed to an office in Home to be sexually abused by a man who she had not seen before. She recollects this happening several times with same man. She estimates she was 4–5 years old.	18
259	Read	1940s–1950s	Westaway Crèche, JHFG, JHFB	Generally happy at Westaway Crèche but life was a bit more severe at JHFB. Was bullied and made to drink urine by boy at Home. Was severely physically punished, beaten in front of other boys, hit on the head with bunch of keys and with flat of hands, leaving huge welt marks. Often did not have shoes, and tar on road stuck to feet. Staff shortage during the War, and witness thinks strictness was needed to maintain order. Said staff member was asked to leave after molesting	16

				a boy. Witnessed sexual assault of a boy by former resident.	
261	Read	1940s–1950s	JHFG, JHFB	Describes as “sadist” a staff member at JHFB who beat him till he bled and a brutal regime of slaps and beatings. Was humiliated for bedwetting by being made to walk around with sheets on his head. Describes being locked in belfry with only bread and water.	16
267	Read	1940s–1950s	Westaway Crèche, JHFG, Elizabeth House	Describes being locked in room at JHFG with only a bed cover for three days, during which she was fed only bread and water. She was punished with a cane. She describes running, terrified and naked, through the Home and being caught and held down by three to four members of staff and thrashed with nettles all over her back and legs for bedwetting. She remembers a member of staff whom she had seen crying beat her black and blue with a shoe when she asked if she was all right.	18
268	Read	1940s–1960s	Westaway Crèche, JHFG, HDLG	Had no idea, throughout childhood, why she was in care. At JHFG, recalls being served porridge for each meal and punished for still not finishing it at teatime. Describes a harsh regime, including cold baths and being made to stand most of night till her hair dried, having nose rubbed in sheets for bedwetting, and children being hit with nettles. She recalls having little free time, as there were so many chores to do. All her childhood, she had no new clothes. She was stigmatised and bullied at schools, and staff at the Home discouraged friendships with outside children. Punishments were dispensed arbitrarily and included being smacked with slipper or shoe and having mouth washed with soap. After a group of girls complained of physically abusive treatment by one member of staff, the carer was dismissed. Had limited contact with family and recalls sobbing because she did not know why she had to be in care. Her memories of HDLG are better. Punishments for girls at HDLG were being sent to their room or extra chores. Experience in care left her with little confidence, independence or social skill to cope with life outside an institution. She feels she lost her childhood and has no recollection of anyone being kind to her throughout her time in care.	139

263	Read	1940s–1960s	Westaway Crèche, JHFB	Describes basic living standards and strict discipline at JHFB. Boys beaten with fists or bamboo cane. A lot of time was spent doing chores around the Home. Tells of being sexually assaulted by a member of staff when he was ill and of same member of staff watching boys bathe. Recounts an incident where large group of boys were encouraged by staff to gather outside and to beat two naked boys with canes.	17
315	Read	1940s–1950s	Sacré Coeur, Foster care	Has positive memories of her childhood at Sacré Coeur, though she regrets being separated from her siblings at the Home and having no contact with them. She says there was no physical punishment at Sacré Coeur. She has fond memories of living there and is grateful to the nuns for the life they gave her. She was sorry to leave Sacré Coeur when she was fostered.	65
19	In person	1950s	Sacré Coeur	Describes a harsh, punitive regime. Children were whacked on elbow with wooden spoon for speaking at mealtimes, punished by being locked in a cupboard under the stairs or restrained in their beds with sheets pulled up over their heads. She recalls one nun who was particularly kind but the rest showed no warmth or affection towards children. Even young children did heavy chores and there was no time to play. When she got her birth date wrong, she was made to walk around the school wearing a plaque saying she was a thief. Bath times involved nuns washing child's intimate areas. Witness now recognises this as abusive.	12
57	Read	1950s	JHFB	Describes being made to perform sex acts on older males in grounds of Home in daytime and being inappropriately touched while in bed at night. Had tried to report this to police as an adult but had been unable to talk about it.	17
133	Read	1950s	JHFB	Was punished physically with leather strap on bare skin and was on one occasion assaulted about head by staff member using bunch of keys. He told adults about the treatment but nothing was done.	17
149	Read	1950s	JHFB	Describes emotional abuse and physical beatings. Says children were addressed by their number in Home, rather than their name. Believes continual beatings around head have left him with a lifelong condition.	139

222	Read	1950s	JHFB	Describes constant beatings and being bullied by staff and older boys because of a condition he suffered. Lived in daily fear of beatings for slightest misdemeanour. Was caned, hit on head and humiliated for bedwetting. He has been told a condition he suffers from as an adult may be result of beatings around head as child.	139
224	Read	1950s	Off-island care	Because of a disability, was sent off island aged nine. Only contact with family was with a relative for an hour each term and allowed home eight weeks a year. Her family worried that the establishment chosen by States had bad reputation. She recounts a cruel regime in an establishment run by nuns. Her pigtails were cut off on arrival, as they were considered a sign of vanity. She describes the establishment as prison-like and Dickensian. She was distressed and depressed. The regime was mainly “cleaning and praying”, with insufficient educational input. She was given no therapy for aspects of her disability. Food was scarce and children were force fed poor-quality meals. She was never allowed outside. She was only allowed to write home what the sisters told her to write. She was caned and locked up for trying to run away. Her parents complained about her treatment. When the school changed to being run by lay staff, conditions and the education improved considerably, but her early experiences left her lacking in confidence and unprepared for adult life. On returning to Jersey, she flourished in mainstream schooling. She recounts the distressing experiences she had as a parent. She contrasts the support she received from Patricia Thornton to seeming indifference of Charles Smith.	139
262	Read	1950s	JHFB	Describes boys being beaten indiscriminately on heads, faces and legs. Also describes “wonderful times” canoeing, summer camps and Christmas. Overall believes that the violence in Home only made boys violent in later life. Believes he averted abuse of a younger boy he thought was being groomed. Describes being mistreated by two Centeniers who he said were “a law unto themselves.”	17

240	In person	1950s	Sacré Coeur, BYD, Foster care.	At Sacré Coeur most of her childhood, after mother died. She was separated from her sister. Life was hard and children had to speak French, as nuns did not speak English. Describes very strict regime with many chores. Children not allowed to look at their own bodies. Pre-teenage girls did all the laundry for the institution, and all the ironing. Aged nine or 10, was working in Summerland factory, clearing fluff from under machines, and spent holidays threading labels for factory. Children were sent begging to local shops for food and crockery. At Christmas, children received one present that had been given to another child previous year. Toys only appeared once a week. Describes harsh and cruel punishments, being confined to bed with a sheet tied over her head, being locked in cupboard or being denied family contact. Felt deprived of a childhood and ill prepared for life – was not able to use a phone or tell time when she left care. Experiences have affected her relationships in adult life.	39
Barrie Ford	In person	1950s–1960s	HDLG	Describes staff as very friendly and approachable, strict but fair. Describes boys being caned occasionally and children who wet bed being made to sleep in wet sheets. Has happy recollections of activities, holidays, good food and special events at HDLG.	38
118	Read	1950s–1960s	Sacré Coeur	Describes nuns as uncaring and strict. She has few memories of her time there. She does recall older girls behaving harshly. Contrasts the experience of Sacré Coeur with that of BYD where she found staff were caring and kindly.	65
126	Read	1950s–1960s	HDLG	Describes large dormitories and strict regime. Was sexually abused by a member of staff and by a visitor to the Home. Complained to a member of staff but was told to stop telling lies. Recounts being punished for talking in dormitory by being tipped out of bed and made to clean corridors at night. He complained about member of staff who threw snooker balls and other items at boys and flicked them on bare skin with towel in showers, causing welts and bruises, but nothing was done.	32
150	Read	1950s–1960s	Sacré Coeur	Had head dunked in barrel of water by nuns for bedwetting. Was held down and had hair forcibly cut off.	24

128	Read	1950s–1960s	JHFB/ HDLG	Was physically punished with cane and slapped. Was slapped by staff member after getting splinter in finger while scrubbing floor. No assistance given, wound went septic and needed hospital treatment. Recalls being humiliated in front of other boys for bedwetting. Describes being locked in room and missing meals as punishment.	17
178	Read	1950s–1960s	Sacré Coeur, HDLG	Recalls Sacré Coeur was “austere, strict and unloving”. Discipline was enforced at mealtimes by a nun striking children on head with metal serving spoon. Was made to work in fields or in Home after school and punished for looking up while scrubbing floors. Punishments included being locked in cupboard under stairs. On Saturdays, WN178 had to go into town with a cart and sell plants and flowers and was punished if all the produce was not sold. At HDLG, was routinely punished with clenched fist or cane “Such punishments were systematic and … commonplace”. Punishments included being made to stand all night in pyjamas in hallway on stone floor, being caned on bare skin on front of whole Home and being made to complete the return journey to school on foot for a week. He recounts how his experiences have profoundly affected his health, confidence and ability to make relationships.	24
202	Read	1950s–1960s	Westaway Crèche, JHFG, HDLG	Memories of JHFG are pleasant ones. Well clothed and well fed, and does not remember being disciplined.	18
338	Read	1950s–1960s	Westaway Crèche, HDLG	Describes resisting inappropriate sexual contact from visitor to Home.	32

129	Read	1950s–1960s	JHFG, HDLG	Remembers having mouth washed out with soap in JHFG and face rubbed in bedsheets for bedwetting. HDLG was better place to live, in her view. Although regime was strict, there were no harsh or humiliating punishments. She found Colin Tilbrook to be kind, and lived in a room in his quarters for a period, as she stayed on at school past leaving age. She was unaware of any abuse of any child. When told by SOJP that other witnesses thought she had been sexually abused, she could not recollect this but accepted it might have happened. She returned to visit HDLG once she was working, and found staff to be less dedicated and she thought they spent a lot of time out drinking on Friday nights.	18
186	Read	1950s–1960s	Westaway Crèche, HDLG	Spent entire childhood in care. Describes older boys who acted as prefects as bullies who picked on younger boys. Recounts incidents of sexual assault by staff member to whose room he was taken by an older boy. Describes punishment being administered by older boys who would beat and punch him. He says treats of sweets were only for Sundays and usually they were taken off him by older boys. His care experiences have damaged him and left him with difficulties in forming relationships.	17
195	Read	1950s–1960s	HDLG, UK residential school	Describes a harsh institutional regime at HDLG. From a young age, had to clean drains and do heavy chores. Describes being taken out on weekends by a male visitor to HDLG, previously unknown to him, and sexually abused on several occasions, at different locations. He also describes being lured by a local man into his home and sexually abused. The experience has affected his relationships and ability to be intimate in adult life.	31
212	In person	1950s–1960s	La Preference, FGH	Describes the head of La Preference as kindly and maternal, although the Home was physically cold and uncomfortable to live in. In general, has no complaints about La Preference. He did experience inconsistent and sometimes punitive treatment from someone associated with the Home. He moved with other children to a FGH. He has positive recollections of the Houseparents.	54

220	Read	1950s–1960s	Sacré Coeur, BYD, HDLG	Recounts being haunted by memories of Sacré Coeur, which was the most terrifying time of his life because of physical abuse. Has only happy memories of BYD. Describes being bullied at HDLG, then punished by staff for reporting it. Describes being physically and sexually abused at HDLG and punished for reporting sexual abuse. Punishments included being locked in detention room for long periods, and describes being sexually abused there by member of staff.	24
236	In person	1950s–1960s	Sacré Coeur. HDLG	Describes “strictly regimented” Sacré Coeur. Babies slept in same room as older children, so rarely got uninterrupted sleep. Food for children was “slop”, while nuns had good food. When given money to buy items for nuns, children would steal the item and use money to buy food. Nuns called children “devils, liars and bastards”. Describes people arriving regularly to pick a child for adoption, with no oversight from Children's Services. Believes it would have been obvious to school teachers that children were being mistreated. He saw his brother fall downstairs, (apparently pushed by a nun) and locked in a cupboard rather than receive medical care. Describes bullying and indecent assault of younger boys by older boys. He and other boys were also sexually abused by a visiting teacher. Describes children being sent out to sell flowers and to beg. Describes being punished by being locked in cupboard, struck and being forced to pull harrow over field. Describes being sexually abused by female staff member at HDLG and seeing other boys abused at staff parties. Recounts harsh corporal punishments and states he twice tried to tell police what was happening but was not believed. No follow-up or support on leaving care. Has found lots of inaccuracies in his records. His care experiences have profoundly affected his adult life.	40
255	Read	1950s–1960s	Sacré Coeur, La Chasse, BYD	Says home was very strict. Recalls punishment of being confined to bed with sheets wrapped tightly round her. Recalls being taken from bed and being made to wash sheets under water pump for bedwetting. Describes life as regimented, with children made to work. Contrasts SC with BYD, which she describes as “a happy place” where the meals were “fabulous” and children were encouraged to play and have fun.	65

265	Read	1950s–1960s	Sacré Coeur, JHFB/ HDLG.	Recollects an 11-year-old boy at HDLG who committed suicide. Now considers inappropriate the contact he had with a visitor who used to take him out, though was untroubled at the time. Remembers being slapped but considers it normal for the time. Remembers other boys being unhappy, but they never told him why. He describes waking in the night to find a boy missing from the dormitory but returned in the morning.	17
434	Read	1950s–1960s	BYD, Foster care	Describes wonderful loving foster care and regular visits by child care officer. Aged 15, she moved into HDLG for a few months and enjoyed her time there. She describes the atmosphere at HDLG as “pleasant”, with firm rules. She was so happy there, she asked to extend her stay before returning to her foster parents.	65
266	Read	1950s–1960s	JHFB/ HDLG	Remembers his mother told him he would not have been admitted to care if she had been willing to sleep with local Centenier. Only official contact with family was every fourth Sunday, when he could meet his mother in grounds of home for a short time. As a result, he frequently ran away, sometimes just hiding outside her house so he could watch her. Describes an occasion his mother pleaded with Police not to take him back to HDLG on account of bruising he had from beatings, but she was ignored. HDLG was "like Oliver Twist". Never enough food. Frequent beatings with cane. He recollects that staff did not record the true number of strokes administered nor how indiscriminately they were applied. Recalls being beaten "black and blue". After two years, Colin Tilbrook came, conditions improved markedly and he recollects no more beatings. He recalls good holidays and encouragement from staff while Colin Tilbrook was in charge.	17

340	Read	1950s–1960s	HDLG	Was told she was going to holiday camp by her social worker and found herself taken to HDLG. Was scared of bullying children and found Houseparents were “particularly cruel”. Recalls being locked in boot room for not being able to answer questions about what was on news. Recollects girls in dormitory having to stand naked and be inspected by female carer. Staff would come into room at night and tip children out of beds. Says she was locked in bathroom, sometimes over a weekend, for not being able to eat certain food. Remembers having an accident and the wound being stitched by a member of staff, causing great pain and bruising. She was told not to tell anyone. She considers the regime to have been psychologically abusive and she believes it has affected her ability to make relationships in adult life.	32
356	Read	1950s–1960s	HDLG, Foster care	Remembers HDLG as strict, with both boys and girls punished by caning and being made to stand in corner for long periods with hands on head. Remembers being very hungry. Was spoken to and touched inappropriately by Superintendent. She remembers complaining to other staff members and to Miss Thornton but nothing was done. Recounts she saw three men break into dormitory and rape other residents twice a week. She has suffered lifelong mental health problems but says this is not due to HDLG experience.	37

337	Read	1950s–1960s	Sacré Coeur, Foster care	Describes SC as a safe and secure environment, with no hint of abuse. He says he grew up free of squalor, in pleasant, orderly surroundings, supported by the principled care, guidance and spiritual nurture of the nuns and has extremely fond memories of his childhood at Sacré Coeur. He describes the chaplain as being of "impeccable character". He considers the work he undertook, cleaning, gardening, and selling produce as formative of his character and not exploitative. He says the meals were basic but he never went hungry. He feels he was given encouragement to achieve educationally. He recalls discipline was achieved through good conduct reports and badges, through time out, including possibly in the stair cupboard. In his 12 years at SC, he never saw "corporate, cruel or harsh" punishment, though he was smacked on face and given "occasional smacking" by one sister. He used to act as translator for the sister, who went door to door asking for money for the poor. He strongly refutes critical accounts of other residents of the period. He commends his social worker for the support provided through foster care and after he left care. He feels the sisters provided a caring environment and did their absolute best for the children, even though they were not experts in child care, and he is profoundly grateful for all they did for him.	139
814	Read	1950s–1960s	Sacré Coeur	Alleges physical abuse while resident of Sacré Coeur, including being whacked on head and legs. Describes having to do heavy outside work. He was sexually abused by a male worker at Sacré Coeur and is still haunted by it. Recalls crying for hours after being locked in a room for running away. He was separated from his sister and no contact was allowed between boys and girls at Sacré Coeur.	139
493	Read	1950s–1960s	HDLG	Was admitted to HDLG, where he had previously lived, after he alerted Superintendent that there was no adult looking after him. He spent a night in secure cell at HDLG because he was unsettled and then an arrangement was made by HDLG to foster him with a couple he knew. He was arrested for an offence and appeared at court and later that day he committed suicide. Contemporaries later reported that he had disclosed to them that he was subject to beatings and abuse during his times at HDLG.	65

452	Read	1950s–1960s	Westaway Crèche, HDLG, Foster care	Admission to HDLG was sanctuary after an abusive home life. Has gaps in her memory but recalls a female staff member who was strict but a mother figure to her. Describes being tipped out of bed by staff and being made to clean a long corridor with a toothbrush and resisting attempts by male member of staff to abuse her sexually in her bed. She recalls Jimmy Savile visiting HDLG and being “tactile and inappropriate”. Her social worker was “wonderful … very caring and gentle”, but tended to be a background figure, although she responded promptly when witness was desperately unhappy in foster care and threatening suicide, and arranged for her return to Jersey and alternative accommodation and remained supportive in early adult life. She has suffered depressive illness she attributes to her experiences and her early life has impacted severely on her adult life.	139
Michael Renouf	In person	1950s–1960s	Sacré Coeur	Describes a harsh regime and the nuns as evil and brutal. Children had to speak French, as few nuns spoke English. He remains a fluent French speaker. The high fences and walls round Sacré Coeur made it feel like “a concentration camp”. Recalls embarrassment of wearing tattered handed-down clothes. Nuns ate fresh produce from garden while children's food was “crap” served on tin plates. Children only bathed once a month, all in same bathwater. Punishments were severe for relatively minor misdemeanours such as speaking in English, and included being locked in cupboard under stairs, being hit with wooden spoons or batons, being made to wear soiled underwear on his head and being denied visits from family. Describes being made to work from a young age, selling flowers, begging and doing heavy chores outside. Says his “childhood years were stolen” by nuns.	61
324	Read	1950s–1970s	Sacré Coeur, Foster care, JHFB/ HDLG	Describes nuns as cruel and recounts how, aged three, he was made to sit on chair balanced on two legs, and was injured when it toppled. At HDLG, describes being physically assaulted in shower, punched in stomach and on kidneys by staff member, being punched and slapped three to four times weekly by same staff member until, after a particularly severe assault, his father complained and he suffered no more physical punishments or assaults. He recalls spending time in isolation rooms. He describes staff as insensitive. Following a change of superintendent, things improved. His care experiences have made	23

				him reluctant to have children of his own.	
Michael Laing	In person	1960s	Foster care, HDLG	Foster carers were violent individuals who beat him regularly by hand and with wooden implements. Was sexually assaulted by member of staff when admitted to hospital. In another placement, was sexually assaulted by a member of the family.	10
91	Read	1960s	HDLG	Describes harsh, punitive regime. Recounts occasions of being taken to a cellar and being sexually abused by member of staff and locked there over a weekend. Attributes later mental health issues to his care experiences.	34
121	Read	1960s	HDLG	Sent to HDLG because of family illness. Was physically and sexually abused by a member of staff. Describes being taken to an underground cellar by a member of staff where men were waiting to abuse him. Says he was abducted from dormitory but rescued by Police. Describes being made to do chores and being in detention room. Believes his subsequent physical and emotional problems stem from HDLG experience.	37
123	Read	1960s	HDLG	Spent eight years at HDLG and says much of time was enjoyable. Describes sexual relationship with married male member of staff who had flirted with her and touched her indecently. She was only 12–13 years old and wanted a father figure and thought this was his way of showing affection and love to her. He approached her for sex again after she had left HDLG. She stayed friendly with his family and it was only in later adulthood that she realised that she had been exploited sexually.	39

172	Read	1960s	HDLG	Sent to HDLG for unspecified length of time by Constable for truanting. Later asked to be remanded in prison rather than HDLG because of fear of HDLG. At HDLG, he spent a lot of time reading and kept to himself. Describes being sexually assaulted in the Home by a visitor. Was made to shower and get shorts wet before being caned for having sex with female resident. Describes sexual abuse of younger boys by older boy. He subsequently told a psychiatrist on island what had happened and was sectioned and not believed Considers his life would have been very different if he had not been so affected by what happened to him at HDLG.	37
180	Read	1960s	HDLG	Said she was placed in detention for several weeks on arrival, with no clothing. Describes initial Houseparents very strict but fair, though they used to call children abusive names like "scum". Was touched inappropriately by member of staff on several occasions. Houseparents used to argue with each other in front of children. Superintendent used to invite her to chat and always turned conversation to sex and made her uncomfortable. Recalls being struck around head frequently by staff	38
209	Read	1960s	HDLG, Foster care	Had found HDLG initially much better than home circumstances. Was repeatedly sexually assaulted and pestered by male member of staff who told her no-one would believe her if she complained. Extended family had asked from outset for foster care but this only happened when she reached leaving age.	39

George Hamon	In person	1960s	HDLG	Was sent to HDLG by court for three years, for shoplifting. Had no idea where he was being taken and recalls the "overwhelming uncertainty" of journey. Describes playing in the space below floor under the building. Found experience positive apart from being separated from his family. Said trip to Sark "was the best holiday I have ever had". Punishment for misbehaving was being made to stand in corner or doing chores. Was never punished physically and had high regard for superintendent and staff. He only ever saw one child placed in detention after barricading himself into hall in extreme distress. Members of his family in an earlier generation had been sent to South Africa for adoption and he understood families there had been given misleading information.	36
335	Read	1960s	HDLG	Spent three years in HDLG for stealing stale cake. Describes it as very similar to Borstal. Enjoyed the food and did not experience any abuse. Describes bathtimes as being five minutes once a week, with only three inches of water. Was hit by other boys with pillow filled with footwear. Says he spent little time in Home – was at school, potato picking or in hospital recovering from accident when climbing cliffs.	36
342	Read	1960s	HDLG	Some punishments which he considered normal at the time, such as being hit, being made to stand all night and doing heavy chores, he recognised in adulthood as physically abusive. Describes a very macho regime where boys were encouraged to fight each other. Recounts young people making a complaint about a member of staff being sexually inappropriate with a female resident but this being disbelieved. Describes boys who suffered from bedwetting being whipped with towel in shower, causing red welts.	34
345	Read	1960s	HDLG	Witnessed abuse of other residents by man living nearby and saw him commit indecent acts.	39
346	Read	1960s	HDLG	Has few memories of either period spent at HDLG. Says "some of the staff were OK". Recalls being indecently assaulted by a male member of staff and smashing a mirror to distract him. Did not tell superintendent what had happened as did not think she would be believed.	39

349	Read	1960s	Sacré Coeur, Foster care, HDLG	Describes being made to stand facing wall for a few hours if talking in dormitory. Staff tipped over beds five or six times and had boys remake them to tire them out if they were arguing among themselves. Had not been a good experience, but he never saw anyone abused in any way by staff.	36
351	Read	1960s	HDLG	Says HDLG was "extremely well run", and superintendents, deputies and matrons were all "extremely caring".	36
353	Read	1960s	HDLG	Found staff to be cold. Days were regimented. Was not harmed or abused in any way. She recalls being forced to eat food she did not like by a strict member of staff, though her vegetarianism was respected and was not made to eat meat. HDLG has not had a negative impact on her.	36
358	Read	1960s	HDLG	Describes being forced to eat and punished for not finishing food, which she describes as disgusting. Says one couple who worked there were protective of her. When they left their replacement was emotionally abusive of her. Was bullied by older girls and sexually abused by a boy of her own age. Was regularly sexually abused by her father when on home leave from HDLG. Also describes being touched inappropriately by Superintendent.	37
359	Read	1960s	HDLG	Was detained in HDLG for two nights, after running away to Jersey and before being returned to UK. During his short stay he states he was sexually abused each night by an unknown male and then again by the person driving him to the airport.	37
398	Read	1960s	HDLG	Was admitted for two short periods of 2–3 weeks. Recalls being thrown down flight of stairs by member of staff into a locked room from which he escaped and went home. He later heard a boy who had befriended him at HDLG had committed suicide. Describes bullying by older boys.	37

421	Read	1960s	HDLG	Has no idea why he was sent to HDLG. He was there a few months and found the staff "extremely friendly". He thought Colin Tilbrook was like a friendly uncle. He enjoyed the range of activities at HDLG and had more fun than he had ever had at home. Apart from missing his grandmother, with whom he had stayed, he found HDLG a happy experience, "more like a family than a care home". He never saw any mistreatment of children and, apart from feeling his admission to HDLG was badly handled, has no complaints.	139
399	Read	1960s	HDLG	HDLG was "worst place to put children in" and "abusive regimented hellhole". Staff were poorly trained and "blatantly did not care" about children. Recounts being tipped out of bed and being made to remake it, being beaten with a cane and stick and having shoes and other objects thrown at him. Says staff used detention rooms as punishment for misbehaviour rather than for remand as intended. He recalls children who were physically abused being told to say they had been in fight with another boy. States he was sexually abused by member of staff. Also describes staff rigging light switches so that if child tried to put on light at night they got a shock. He absconded frequently to escape regime, even reaching the UK.	38
604	Read	1960s	HDLG	Was admitted for protection and had no significant complaints about HDLG. Spent much time looking after younger children, which she enjoyed. Was sad to leave HDLG. Was locked in detention once which was frightening because of her fear of confined spaces. She had run away because was upset at prospect of leaving. Recounts being made to sit at table and finish meal though it made her sick.	139
634	In person	1960s	BYD, La Preference	Describes BYD as "strange" and recalls being beaten for misbehaving. Recounts being very frightened at La Preference and describes being physically abused by a staff member. He recalls the older children had to care for the younger children including washing them. Recalls being punched and knocked out for no apparent reason by someone helping in the Home.	63

894	Read	1960s	Sacré Coeur	Recollections of Sacré Coeur are dominated by abuse. Gives her recollection of being sexually abused by Jimmy Savile when he visited Sacré Coeur in 1969. She also recalls being abused by a male visitor who stayed at Sacré Coeur. She reported both incidents to a sister and to a priest at confession, and each time had her mouth washed with soap. She describes the nuns as "quite vicious" and recalls being locked in a cupboard under the stairs. She describes on one occasion she was whipped so severely that she was kept from school for two weeks till her injuries healed. She describes working after school making tags for garments produced in the Summerland factory. She says she has not been able to describe the full extent of what she experienced as retelling it is so distressing.	139
807	Read	1960s	Sacré Coeur	Was the last child to be admitted full time to Sacré Coeur. Describes nuns as very strict but did not witness any abuse of residents. He says children were smacked if they misbehaved. He says his childhood felt like being locked up in a prison but that he retains great respect for the nuns who cared for him.	144
45	Read	1960s–1970s	HDLG, FGH, La Preference	Recalls HDLG as very regimented and strict – an unpleasant place. She recollects being locked in a dark storage area as a punishment and children being hit with wooden spoons for not eating meals. Describes life in FGH with WN279 and WN281 as "a nightmare". Describes WN279 as a violent person who used frequent corporal punishment including with broomstick, hairbrush and plastic bat. Describes treatment as "brutal" and recounts rough-handling by WN279. Says food she was given was sometimes rotten. Describes being confined to a small room for six weeks and being made to help with heavy household chores and childcare and having to deal with a medical emergency. As time went on, she says WN279's behaviour became more aggressive and she lived in constant fear of daily beatings. Says she was asked at school about marks on her but was frightened of repercussions if she disclosed physical abuse. Her impression was that children's officers came to see adults not children. Describes being sexually exploited over long period time outside the FGH. Apart from an incident where she was struck on the face by staff member for drinking, she found La Preference a better living situation,	58

				though she describes it as "a free for all between the older children and there was a lot of sex going on". Describes how her life has been affected by her "appalling" upbringing in care system and believes much of ill treatment she describes should have been spotted. Also recollects a visitor to Home who used to make children lie across his knee and look for chocolate bars secreted in his clothing.	
122	Read	1960s–1970s	HDLG	Describes HDLG as “the best home I could have hoped for as a child”. Did not see punishments (caning, use of detention room) as excessive. Describes children being made to watch the news and then answer questions on it. Children were punished for wrong answers by standing in corner for hours. Was sexually abused by another child at HDLG. Was forced to leave HDLG with no preparation for living independently.	52
135	Read	1960s–1970s	HDLG	Recounts being sexually assaulted by three different male members of staff, several times.	37
136	Read	1960s–1970s	HDLG, FGH, Off-island care	Was sexually assaulted by man living nearby while at HDLG. Says she was shown no sympathy when she disclosed this and felt she was being punished. When she ultimately left care, she had no support and was homeless and ended up staying at a shelter where her abuser lodged.	38
140	Read	1960s–1970s	BYD HDLG	Recalls a strict, punitive regime and being physically chastised for minor issues. Remembers being locked into bedrooms at night which he found frightening. He says he has blocked out a lot of his childhood because of unpleasant associations. Was later fostered with three different families. In two settings, he was very happy but in the last and longest he was sexually abused by his foster father. Aged 15, he was told to leave with no notice and spent the next few years with the family of a friend who provided a loving home for him. His abusive experiences in foster care have had a profound effect on his health as an adult.	64

147	Read	1960s–1970s	HDLG, FGH	Says of HDLG "you were so used to getting punished it just became the norm" – even from pre-school age. First experience of FGH was very positive but when Houseparents left they were replaced by a couple who used “over the top discipline”. He returned to HDLG where his experience of some staff was very positive. Alleges he was sexually abused by a man who wore a cape and also by a member of staff and by another boy at HDLG. He says he went on to have a relationship, which he describes as “consensual”, with the other teenage boy. He describes “a lot of foreplay” between older boys at the Home.	35
152	Read	1960s–1970s	Sacré Coeur. HDLG	Describes nuns as cruel and vicious. Recalls seeing a nun use a young child who had accidently wet themselves “like a human mop”. Describes some staff at HDLG as kind and others as “spiteful”, with a “nasty demeanour”. He recollects being served with the same food over and over till it was eaten. He says “authorities labelled me as a retard” – a stigma that has affected him despite his educational success after he left HDLG.	23
158	Read	1960s–1970s	HDLG, Care/foster care off island	Describes HDLG as “like heaven” compared with his home circumstances. Describes regime as “army-style”– a regular, strict routine. Punishments included caning. States he was indecently assaulted in presence of member of staff and another male and by an unknown person while he was in bed. He recalls seeing older boys assault a younger boy in bed and being made to commit a sexual act on another young person. Recalls complaining to Superintendent but nothing was done.	37
162	Read	1960s–1970s	HDLG	Was admitted to HDLG after sustained ill treatment at home. Initially, was happy to be away from home. When new staff arrived, regime at home became punitive, with regular beatings and assaults, including being whipped with wet towel and being thrown into patch of nettles. “There wasn't a day went by without getting a slap, kick or derogatory remark.” He was visited weekly by his grandfather and staff would stop contact to punish him. Was treated unsympathetically when his grandfather died. Was caned from an early age until he cried. Recounts being indecently assaulted by member of staff, including while in detention. Describes staff throwing objects like snooker balls	40

				at him and punching, beating and kicking him. Describes time an intruder broke into dormitory and left with another boy. Describes how his whole life has been blighted by care experiences.	
171	Read	1960s–1970s	HDLG, FGH	Went to HDLG aged four. Says “there was no love or family atmosphere, it was just a place to eat and sleep”. Says he was sexually abused twice by superintendent and told the matron, who did nothing. Describes being assaulted at FGH and reporting this to social worker who did not believe him. Was ill treated at FGH and returned to HDLG, where he says another member of staff raped him.	35
188	Read	1960s–1970s	HDLG	Was sexually abused by Tony Watton, whom he describes as a “man from hell”, over a long period of time. He says the abuse only stopped when he became big enough to challenge his abuser. He also recounts physical abuse from Gordon Wateridge, whom he describes as “horrible”, including tipping up his bed and throwing the mattress on him.	59
174	Read	1960s–1970s	Foster care, HDLG	Was ill treated in foster care, locked under stairs, ducked in barrel of water and was removed after someone alerted Children's Services and placed at HDLG. Describes being struck by objects thrown by HDLG staff member, being thrown across a room, not allowed to use toilet and locked in detention room. Describes HDLG as a "nightmare". Describes boys being made to watch weather report on TV then being quizzed on it and struck if they got details wrong. Recalls an occasion where someone broke into dormitory and left with child known to them. Describes same food being placed before him for days till he ate it. Bullying by older boys was not tackled by staff.	35
184	Read	1960s–1970s	HDLG	Describes home as "horrific". As he got older, he ran away frequently and was always severely physically punished on return. He says he asked police officers not to return him to HDLG. He describes "violent" canings and being slapped, punched and kicked, being hit with wet towel in showers and having hard items like snooker balls thrown at him. Believes staff avoided hitting children where evidence would be seen. Describes being locked in cell-like conditions in detention room for days.	32

187	Read	1960s–1970s	La Preference, HDLG	Recalls being slapped once at La Preference for breaking the vegetarian regime. When he transferred to HDLG he experienced bullying. He describes Ray Williams as “really wicked, really cruel” but found some other members of staff supportive. Describes being sexually abused while at HDLG by three persons from outside, Thomas Hamon with whom he attended a youth organisation, the parent of a school friend, and Tony Watton. Contemporaneous records show HDLG staff were reluctant to investigate the families of children's school friends.	59
318	Read	1960s–1970s	FGH	Describes regular beatings and a "horrible" environment. Described being rapped on knuckles with knife for talking at mealtimes. Considered that children of the family were treated preferentially. Describes being locked in cupboard under stairs. Also recollects a visitor to Home who used to make children lie across his knee and look for chocolate bars secreted in his clothing. Has significant gaps in her memory because she feels she has blotted out events.	59
191	Read	1960s–1970s	HDLG, Foster care	Was at HDLG from age one year. Recalls being hit by Morag Jordan with wooden sandal. Told Superintendent who said there was nothing he could do about it. Other punishments included being made to stand facing wall for long periods or children being made to sit in circle for hours till someone owned up to misbehaviour. Recalls that if food was not eaten it was represented at subsequent meals until it was consumed. Overall, hated time at HDLG but has good memories of Christmas at HDLG and of a member of staff who was kind to her.	46
197	Read	1960s–1970s	HDLG, Foster care	Spent most of his childhood in HDLG which he describes as "an awful place" with a constant atmosphere of physical violence, including bullying of younger children by older children which went on unchecked by staff. Remembers being regularly caned. Describes Morag Jordan as "horrible" and "too harsh to be looking after kids", and says her treatment of children was beyond words. He recalls being hit with a metal spoon and hit across the head by her. He recalls being made to stand in a corner for long periods of time, in his underwear. Remembers Tony Watton at HDLG attempting to touch children and making inappropriate remarks. He describes an	46

				attempted sexual assault by another boy, which he reported to staff but was not believed. He recalls being thrown against a wall, thrown downstairs and beaten by staff. Says "the whole atmosphere of the Home was based around violence and aggression". Describes many children self-harming. He found it impossible to adjust to the freedom and nurture of foster care after his abusive experiences at HDLG. His childhood experiences have profoundly affected his adult life and impaired his ability to have relationships.	
205	Read	1960s–1970s	BYD, La Preference	Describes sexual abuse by male connected to staff member at La Preference. Describes inappropriate behaviour from Ted Paisnel who visited the Home. Also recalls being locked in her room all day without food and being slapped by a member of staff.	55
214	Read	1960s–1970s	Westaway Crèche, BYD, HDLG, FGH, La Preference	Describes abusive experiences at FGH, particularly after WN279 recovered from serious illness and "her tolerance level was at zero". Recalls being hit with heavy hairbrush, resulting in hearing damaged, being locked in cupboard under stairs and regular beatings, one of which caused her to lose two teeth. Recounts being made to do heavy chores and being given outdated food and confined to certain areas of the Home while children of the family had different food, experiences and used other parts of the house. Contrasts care with the positive experience and warmth experienced from replacements for WN279 and WN281. Describes feelings of worthlessness she had at La Preference because of staff attitudes. Describes being sexually exploited and assaulted outside care home and by three older boys at La Preference. Describes there being no aftercare when she left the system and having to disguise her background for fear of stigma. She believes the care system failed her miserably.	58
233	Read	1960s	HDLG, Foster care	Describes harsh regime, with frequent canings and unsympathetic treatment of bedwetting, which left him in constant state of fear. Describes member of staff who would turn boys out of their beds at night and force them to remake beds over and over. Does not believe discipline at HDLG did him any harm, though he describes the place as "sad". Praises foster carers for care of his family.	34

124	Read	1960s	HDLG	Describes being sexually abused in night by a man, whom he says was in a relationship with a female member of staff who also behaved towards him in a sexually inappropriate way. Abuse also occurred in field near HDLG.	34
319	Read	1960s–1970s	FGH	Describes physical and emotional abuse by WN279. Says he was regularly punished with bat and recounts an incident where he was struck by WN279 repeatedly and violently to the head. Also recollects being smacked by WN281, including with a coat hanger. Describes being struck by WN279, causing him to slip and hit his face against bath. He says he told social worker about the incident. Says that presents sent to him from his mother were either not given to him or were repackaged and he was told they were from someone else. Describes his time with WN279 and WN281 as “the unhappiest time of my life”. School expressed concerns about bruising on WN319 and care of children in the Home, but these were not thoroughly explored by Children's Services. He raised a complaint in 2000, but this was not investigated.	59
327	Read	1960s–1970s	Sacré Coeur	Spent short periods of time at Sacré Coeur and has good memories of time there. Only work she can recall doing is making tags for garments at factory which she looked on as fun not a chore. She never saw anyone receive physical punishment. She enjoyed her time there so much, she cried when she had to leave.	65
320	Read	1960s–1970s	Westaway Crèche, BYD, HDLG, FGH	Says he has “fond memories” of his time with WN279 and WN281 and is still in contact with them. Has no complaints of mistreatment and states any punishment, which would be "no more than a smack on the backside” or being sent to his room, was well deserved. Describes the household as "structured", with emphasis on good table etiquette. He says he felt secure in the care of WN279 and WN281 and has no recollection of any child being mistreated. He saw no distinction made between foster children and natural children. He says he is grateful for his upbringing and for what WN279 and WN281 have enabled him to achieve in life.	59

343	Read	1960s–1970s	BYD, HDLG	Remembers little about short periods of time at HDLG. Believes children on short-term placements were treated better than those permanently resident there. Recalls resisting attempt by older child to sexually assault her.	52
341	Read	1960s–1970s	BYD, HDLG, Foster care	Thought BYD was a great place. Was petrified on arrival at HDLG. Describes it as a cold and unloving place where brutal punishments were inflicted by uncaring staff. He describes one male member of staff as "sadistic" and recalls being punched frequently by him. Recalls punishments of heavy chores and having his hands stamped on when he was not working fast enough. He was humiliated and punished for bedwetting. Recounts being sexually abused by male and female members of staff. Describes being placed with physically abusive foster carers who beat him severely. He recounts being sexually abused by foster mother. Later he was fostered by someone whom he says was "brilliant" and for first time made him feel "like a human being". He says he was in effect paid to leave the island after a serious of offences stemming from the trauma he had experienced as a child. He describes the physical and emotional scars that he has been left with from his experience of the care system in Jersey.	139
344	Read	1960s–1970s	Foster care, BYD, HDLG, Off-island care	Spent most of childhood in care mainly at HDLG. Was indecently assaulted by man living nearby.	39
348	Read	1960s–1970s	Sacré Coeur, HDLG	Describes abusive regime at Sacré Coeur and recalls, as a small child, a nun rubbing his face with faeces after he soiled himself. At HDLG, describes a regime of military style discipline. Recalls bullying by member of staff and Mr Williams using violence to intimidate boys, punching, flicking with towel in showers and tipping them out of bed. Describes seeing Gordon Wateridge behave inappropriately with girls. Has been most affected by the emotional abuse of living in the oppressive atmosphere of HDLG which he felt was geared to break the spirit of residents.	59

321	Read	1960s–1970s	HDLG, FGH, La Preference, Les Chênes	Told SOJP he had "good and bad" experiences in care system. Describes FGH with WN279 and WN281 as "a happy place" and a nice home, with every child treated the same. Says occasional smacking as punishment was generally merited and that no-one was ever struck with an implement. Describes WN279 and WN281 as "too kind" to have mistreated children.	58
350	Read	1960s–1970s	HDLG	Spent over 10 years at HDLG. Enjoyed time at HDLG, in the main. Says he was well looked after by staff, well fed and given presents at Christmas. Describes one member of staff as like a mother to him. Describes being caned and on one occasion sent to detention room but believes these were appropriate punishments and regime has stood him in good stead.	36
396	Read	1960s–1970s	BYD, HDLG	Spent almost all of her childhood in care until aged 18. Describes being touched inappropriately by member of staff.	38
400	Read	1960s–1970s	Westaway Crèche, HDLG, Foster care	Says all his experiences in care were good. Describes seeing girl being inappropriately touched by member of staff and another male but girl recalls this only as “play fighting”. Recounts being sexually molested aged 12 by female member of staff. Experienced corporal punishment but says this was normal for the time. Says he was not mistreated in any way and has not been affected by time in care.	40
592	Read	1960s–1970s	HDLG	Describes HDLG as “paradise” compared with her home environment. Says staff were strict but “great”.	59
28	In person	1960s–1980s	Westaway Crèche, BYD, Les Chênes, HDLG	Was at HDLG for almost whole childhood. Was physically and sexually abused by staff, other residents, a child care officer and visitors throughout his time there, but most frequently between ages of nine and 13. Recalls one member of staff who tried to be protective of him and saw he was being particularly targeted by Morag Jordan. Describes staff as violent, showing little warmth or kindness to the children. Children were routinely fined, sent to detention, slapped or caned for misbehaviour. Felt punishment went beyond what was normal at the time and was abusive. Describes Morag Jordan as "an evil, evil woman" who hit children with metal serving spoon and force fed them food they disliked. Describes being sexually abused by male and female staff members and being punched, kicked, hit with a stick	43 and 46

				and locked for hours in a wicker laundry basket as punishment. He recounts being sexually assaulted on different occasions by four residents. He describes being caned by a female staff member till he bled and being hit by “anything that came to hand” by another staff member. Describes a gang system at HDLG with rivalries and violence between the groups and a highly charged sexual atmosphere among young people. Acknowledges his participation in gang and sexual behaviour and attributes the violence to learned behaviour from the way children were being treated, from having had no formal sex education and no idea of the concept of consent. As an adult he tried to raise concerns about what had happened to him but these were not followed up. Believes as a consequence of the mistreatment and abuse he suffered at HDLG has spent most of his adult life in prison.	
167	Read	1960s–1980s	HDLG, Foster care	States she was sexually abused by person in household of foster carers. She describes trying to prevent him assaulting a sibling. When she told her foster carer what was happening she was slapped and called a liar. Describes violence towards children from staff at HDLG. Recounts sexual assault by stepfather of friend who took them out from HDLG in his car. Told her social worker of her “deep dislike” of HDLG but he was reassured by staff this was not the case. Her main concern was that the environment at HDLG did not enable her to study and she was intent on pursuing academic qualifications. Her social worker was sceptical of her ambitions and offered little in way of support. Aged 16, she took matters into her own hands and, with the support of a boyfriend, moved out of HDLG, into accommodation he had helped her find. She was later offered foster care by a teacher who recognised her academic potential and moved there till she left Jersey for higher education in the UK.	139

175	Read	1960s–1980s	BYD, Foster care, Sacré Coeur, HDLG, La Preference	Remembers being beaten in first foster home. Thought Sacré Coeur was not a particularly nice place, but remembers most of the nuns were nice, apart from one, who would hit her on head with spoon at mealtimes. At HDLG, recalls one very unpleasant female member of staff who hit her lots of times. At one stage, she and another child went to complain to Children's Officer about their treatment at HDLG but nothing was done. Her memories are incomplete because of all the moves she experienced. Her care experiences have left her insecure and lacking confidence, nervous and for many years she blamed herself for having been in care system.	139
192	Read	1960s–1980s	HDLG, Foster care	Spent entire childhood in HDLG, where she was abused. Describes Morag Jordan as “really nasty” and being hit and pushed downstairs by her. Tells of being served same plate of food over and over till it was eaten. Tells of being hit with wooden spoon, having mouth washed with soap and being made to stand in corner for long periods of time. Was sexually abused outside HDLG and reported this to staff but nothing was done. Recalls one member of staff and police trainees being particularly kind and helpful. Recalls being told by social worker that if she was good she would go to a proper home where someone would love her. When in detention cell, aged about nine, she says she had her head pushed in urine by Morag Jordan. Describes detention cell as Spartan and “like prison”. Has recollection of being sexually assaulted when on camping trip at HDLG. Contrasts HDLG with loving, caring foster home she later experienced.	46
9	In person	1970s	BYD	Experienced physical abuse at home, beatings, biting, having boiling water poured on her. Explains that, despite visits from Police and Children's Services, and WN9 telling a social worker about her mother's maltreatment of her, nothing was done and she was more severely punished by her mother for disclosing abuse.	14
13	Read	1970s	HDLG, Les Chênes	Says “life at the Home was hard”. There was no family atmosphere. Children were always fighting and being separated and moved around the Home so it was difficult to sustain friendships. Describes Morag Jordan as “a nasty piece of work”. He recalls her hitting him with spoons, slapping him and humiliating him including making him stand in corner in his underwear in front of other children. Recounts that a	46

				visitor to Home, Tony Watton, attempted to touch him indecently. Says he was put in detention cells for up to three months for trivial misdemeanours. Describes many of the residents as “disturbed” and that self-harming was common. He was sexually abused by another resident on two occasions. After the second time, when he says he was held down by two boys and raped by another, he reported the incident to staff, but was not believed. He says he suffered a breakdown as a teenager due to his ill treatment. He was moved eventually to Les Chênes, which he describes as very strict but much preferred to HDLG. He says at Les Chênes the regime was better and the educational programmes were good. As a result of his institutional experiences, he has struggled to trust people and build relationships in later life.	
38	Read	1970s	BYD, HDLG	Was at HDLG from an early age. Recalls Morag Jordan as impatient, aggressive and violent: someone whom children were terrified of. Did not experience much physical abuse but witnessed other children being regularly hit. Welcomed going to school to get away from HDLG. Has recollections of men unconnected with HDLG visiting on Saturdays, including Tony Watton, and has indistinct recollection of sexual abuse. Believes period in care and separation from family as a child affected him deeply in adult life.	49
48	In person	1970s	BYD, HDLG	Describes extensive physical abuse at HDLG, and also claims he was sexually assaulted on multiple occasions by male staff and saw others sexually assaulted and threatened. Describes being burned repeatedly by cigarettes and being assaulted with a knife by WN7. He made a complaint to police two years after he left HDLG, but this was not taken forward after WN7 denied the allegations.	50

67	In person	1970s	HDLG	Initially was impressed by security and conditions at HDLG after traumatic home life. Found some of the staff to be kind, but describes Morag Jordan as “absolutely awful” and “very cruel”. Morag Jordan subjected her to emotional and physical abuse, including force feeding her food she disliked. She described how Morag Jordan embarrassed and humiliated her about her background. She found that having been in HDLG stigmatised her when she tried to find employment, and she had to explain she was there for her protection.	50
74	In person	1970s	Westaway Crèche, Foster/ adoptive care, HDLG	Was mistreated in adoptive family. Moved to HDLG for six years, with no preparation. Was terrified at HDLG and confused and unhappy because of all the moves in his early life. He became withdrawn and did not mix much with other children. Describes being terrorised by Morag Jordan, who was physically abusive, lashing out, dragging children around by their hair, humiliating them and shoving bars of soap in their mouth. Feels he had a routine, not a life, at HDLG, and that there was a lack of human emotion from staff, who tended to see children as a hindrance rather than needing care. He was constantly belittled and lost all confidence. At school he was stigmatised because he lived at HDLG. He was groomed and sexually abused by Tony Watton, who volunteered at HDLG. Describes “two years of absolute hell” when Gordon Wateridge came to HDLG. Remembers Wateridge as “a bully and a very violent man”, who would punch him in places where bruising would not be evident. Describes children being placed in detention cells on any pretext when it suited Gordon Wateridge. Describes being treated like an animal and dragged downstairs and along corridor to detention by Gordon Wateridge. Was given no support when leaving care. He was encouraged by Children's Services to go and live with his birth mother, without any preparation, and the situation broke down. His adult relationships have been badly affected by his care experiences.	44
137	Read	1970s	HDLG	Recounts being sexually assaulted by a male and by a female member of staff. Believes she may have become pregnant by staff member and suffered miscarriage. She was sexually assaulted by a male while attending leisure activities and says she reported this to Superintendent, who appeared to do nothing. Had a general feeling of	43

				fear and powerlessness at HDLG.	
98	Read	1970s	HDLG	Admitted, aged four. Says she has blocked out memories. Can recall being roughly handled and bruised by member of staff for something that was not her fault, aged eight. She ran away to her mother and showed her and Social Worker bruising but nothing was done. Remembers children were sent outside to play a lot. She recalls being forced to eat all the food on her plate and kept in dining hall for hours till she finished a meal. Children were made to watch news on TV and retell items to staff with mistakes being punished. “Christmas was not a happy, loving or magical time.”	45
119	In person	1970s	HDLG	Was admitted for protection and started faring well at school because she was receiving regular meals and care. Did not receive any support for all she had experienced in earlier life, but found two of the carers at HDLG were particularly kind and supportive. Describes the regime at HDLG as very strict and punitive, particularly towards boys. She witnessed an attempted suicide by a resident and summoned help. She was given no support for what she witnessed. Feels exploited by female member of staff, who made her take off all her clothes. The incident has had a long term effect on her. She struggled to study at HDLG as there were no facilities and “always screaming or upset children around”. Was given no support on leaving care.	53
138	Read	1970s	HDLG	Initially, HDLG was a refuge from his home circumstances: “for the first time in years I felt safe”. However, became concerned by the homosexual behaviour among boys in his dormitory. He struggles with partial memories of the period. He recalls being abused by a female visitor on multiple occasions including at HDLG and by another female and female member of staff. He ran away from HDLG and when he was caught by police he says was assaulted, reported it to Superintendent but nothing was done. He spent a period that he estimates to be two weeks in detention. When he left HDLG and was still in care of States, he became homeless and was offered	46

				accommodation by an acquaintance. This turned out to be a situation where he was sexually abused and exploited by males whom he believes were part of a paedophile ring.	
146	Read	1970s	BYD, HDLG, FGH	Was separated from siblings when admitted to FGH and lost contact with them. Contrasted FGH favourably with HDLG. Returned to HDLG and describes spending up to a week at a time in detention, wearing only underclothes on many occasions. Was sometimes forcibly manhandled into detention. Recounts staff member stamping on his hand and breaking a finger, and wound later becoming septic.	22
151	Read	1970s	HDLG	Describes being admitted aged 14, and working at home looking after younger children. Initially found male Houseparent charming and kind then was subjected to indecent assault by him several times.	38
155	Read	1970s	HDLG, Foster care	Was placed in HDLG as a baby. Describes institution as “quite cold, not a loving place, there was no warmth”. Was treated harshly over enuresis. She recounts how a hospital letter said there was “quite a bleak outlook for this little girl”. By contrast, when she moved to a loving foster home her problems ceased in a very short time. Describes staff as cold and unapproachable, never giving comfort. Recalls incidents on HDLG camping trips, including sexual contact from older boy and being beaten by a member of staff for being frightened of a bee. She says staff were “cruel, they spoke to you as if you were nothing”. Describes Morag Jordan as “just always angry”. Her time at HDLG has had a major impact on her as an adult, leaving her insecure and frightened and overprotective of her own family.	45
170	Read	1970s	HDLG	Is not sure why he was sent to HDLG. Recalls being punched in arm, kneed in leg and punched in stomach to point where he could not breathe by member of staff. Describes being put in cellar for bedwetting. Recounts being beaten by other boys and pounded with pillows stuffed with shoes. Describes a fear-laden atmosphere and no assistance or guidance for children in need. Feels that his later life would have been different if HDLG had provided a safe, friendly environment. He says that overall his memories of HDLG are “quite good”. When things got bad, he tended to abscond.	46

177	Read	1970s	La Preference, HDLG	Spent several short periods in each home. He disliked the vegetarian regime at La Preference and being separated from his siblings, but otherwise had no complaints about time there. Describes HDLG as “daunting” and Morag Jordan as “scary”. He says children were left a lot to their own devices and there was little engagement with staff. While at HDLG, he was repeatedly sexually abused by an older resident. He also recalls an incident when an older resident assaulted an infant at HDLG.	65
200	Read	1970s	Foster Care, HDLG	Describes a member of HDLG staff being like a mother to her, but says generally staff were not too interested in children. “There was no love and we were just objects.” Describes being made to stay up all night, washing nappies, for misbehaving, and being threatened with not being able to see her parent as punishments. Describes being sexually abused by an older resident of HDLG on a regular basis. Recounts incident where Morag Jordan struck her, causing her to fall downstairs, but believes this was not intentional. Recalls being intimidated by WN7, whom she believed was handling her in a sexual manner. In a letter written when she was in HDLG, she threatens suicide if she is not moved home or to another institution because she could not bear HDLG.	59
201	Read	1970s	Sacré Coeur, La Preference	Describes La Preference experience as “generally fine”. Carers were strict and administered corporal punishment for misbehaviour. Overall, he believed he was better cared for at La Preference than he would have been at home.	55
206	Read	1970s	BYD, La Preference, HDLG	Disliked La Preference, as did not enjoy vegetarian regime and was ridiculed for bedwetting. At HDLG, he describes being physically and sexually assaulted by a member of staff. He describes spending days in detention cell, dressed only in underwear. His time at HDLG was unhappy. He describes Morag Jordan as “scary”. He was humiliated over bedwetting. After he left HDLG, he returned to give presents to his siblings, which they never received.	52
211	Read	1970s	HDLG	Admitted for several months, aged 14. Helped look after younger children. Says “some of the staff were fantastic”, while others “did not care about the kids”. Was indecently assaulted many times by	38

				Gordon Wateridge, whom she describes as a “disgusting” man. HDLG made her feel worthless and useless and she found it a worse place than the home situation she was removed from to protect her.	
213	Read	1970s	Foster care, HDLG	Describes HDLG as “there was no caring or love or anything. It was really evil”. She describes the staff as untrained and unsuitable, frequently belittling the children. Describes being dragged along corridors and thrown in shower and then in detention cell after absconding. She describes being sexually assaulted by another resident and threatened by him. She did not report this, as she feared it might prevent her from being discharged from HDLG.	48
215	Read	1970s	HDLG, Les Chênes	Spent two months at HDLG. Two weeks were spent sleeping in detention cell. Never experienced any abuse at HDLG. Initially spoke “in glowing terms” about Les Chênes and said strict discipline had been helpful. Some years later, he said he had been deliberately suppressing painful memories and described lifelong nightmares about Les Chênes and being physically and verbally abused, denied home leave regularly and being forced to undertake heavy manual labour maintenance work around the establishment. Describes being regularly hit and thrown against a wall by WN108.	51
217	Read	1970s	HDLG	Describes HDLG as “the lost soul department”. She describes feeling on tenterhooks the entire time she was there. She recollects that residents nicknamed it “Colditz”. She says residents could not relate to staff. She recalls being sexually assaulted by a male member of staff and being solicited for sexual favours by a social worker and by someone living near HDLG. As an adult, she reported the incident with the social worker (who was still working with children) to another member of children's services but did not hear if anything happened following her complaint. She believes medication was given to her inappropriately while she was at HDLG.	48
218	Read	1970s	HDLG, Les Chênes	Was remanded to HDLG before Les Chênes became fully operational. While at HDLG, was sexually assaulted three times by another resident. He complained to staff and to his parents, who raised matter with staff.	46

249	Read	1970s	Westaway Crèche, HDLG, FGH	Did not witness any abuse at HDLG. She was given medication, which she believes was never monitored, until she went to FGH, when it was stopped. Describes having a great childhood at FGH, though the Hughes were strict disciplinarians. Recounts Les Hughes having inappropriate sexual contact with her.	22
282	Read	1970s	FGH	Recounts being made uncomfortable on one occasion by Les Hughes and being sexually abused by him on two further occasions. Has had lifelong impact on her and affected her relationships. Describes making a staff member aware of what had happened and being told to consider impact allegations would have on Les Hughes and his wife.	22
296	Read	1970s	HDLG, FGH	Recalls Morag Jordan being “totally uncaring”. Was bullied by older boys. Life in the Home was very regimented. Was caned once and was aware of other children being confined in detention or made to take ice-cold baths. FGH was less regimented than HDLG and more family oriented.	22
352	Read	1970s	HDLG	Was sent to HDLG by Children's Services, aged 15, for her protection, to work as a domestic. Had a positive experience at HDLG. “All the staff were brilliant.” She found staff sympathetic and helpful. She felt it was a safe place that had helped her deal with abusive experiences at home.	36
374	Read	1970s	HDLG	He felt relieved to be placed at HDLG because of experiences at home. Was often placed in detention rooms. He did not see any children ill treated nor experience what he considered mistreatment at HDLG. He describes an incident where a member of staff injured the hand of a young person as “a joke gone wrong”.	48
377	Read	1970s	HDLG	Describes sexual advances by female member of staff and a sexual relationship developing with her when he was aged 13–14. He stayed with this member of staff when he left care and, again, sexual relations took place. He had told other children at the time that he was having relations at HDLG with the staff member.	48
384	Read	1970s	HDLG, Les Chênes	Recalls he was violently shaken by Morag Jordan and injured his neck, but did not receive treatment for three days.	43

381	Read	1970s	BYD, HDLG, Foster care, La Preference	Was told by social worker she was “going on a little holiday” to HDLG. Remembers constant fear of Morag Jordan, whom she describes as “a cold, hard woman” and “scary”. Morag Jordan always called children by their surnames, was physically abusive to WN381 and also made her run around a room late at night till she was exhausted and dizzy. One member of staff was particularly nice to her but she was fearful of disclosing her treatment by Morag Jordan lest that person turned against her. She describes La Preference as “warm and homely”.	43
385	Read	1970s	HDLG	Remembers it as a rough place. Was afraid of a female member of staff. Children were neglected and had little contact with families. When he was at Home, he describes being physically abused by WN7 whom his mother had asked to discipline him.	52
Luis De Abreu	In person	1970s	FGH, Foster care, HDLG	Has only positive memories of the FGH. He became quite frightened of foster carer, who found fault with everything he did and constantly reminded him of the cost of looking after him and threatened him with removal to HDLG. He was devastated by the rejection by his foster carer, as he was still coping with grief from the illness and death of his mother. He found HDLG regimented and strict. He developed strategies for fitting in and coping there. Describes many rules and regulations, frequent chores and recalls children being placed in detention for misbehaviour, sometimes being dragged there screaming by staff. He describes punishment by caning, which he said was not uncommon for the time. For the most part, he enjoyed his experience at HDLG, relishing the activities he was allowed to go out and participate in and the holidays. He found separation from his siblings hardest thing to bear. At school, he felt stigmatised because he lived at HDLG. He enjoyed the camaraderie at HDLG and made many friends. He describes children belonging to different gangs within the institution. He describes bullying and repeated physical abuse from two boys at HDLG and fighting off predatory sexual advances of another boy. He reported the boy to staff felt his complaint was taken seriously. As an adult he did not want his attempted abuser charged as he felt he was a victim of the care system. Opportunity for him to be fostered as a teenager was lost	60

				when the family interested was wrongly told he did not wish for this. On leaving care he was supported by Danny Wherry, whose advocacy and assistance enabled him to become independent and have a career.	
391	Read	1970s	HDLG	Found some aspects of experience positive compared with home circumstances. States that he was physically assaulted by members of staff, including WN7 and Morag Jordan. He recalls Morag Jordan striking him with knuckled fists in a temper. Describes Mario Lundy as “a bully”. No provision was made for aftercare when he left HDLG.	52
397	Read	1970s	HDLG	Describes HDLG as very strict and Houseparents as “not very nice”. Children constantly shouted at and made to do chores repetitively. Punished by being made to run round field in pyjamas. One staff member used to put hot spoon on her hand if she had not done chores perfectly. Was indecently assaulted by Gordon Wateridge on several occasions. She said girls just became used to this behaviour. When she left HDLG there was no aftercare.	38
589	Read	1970s	BYD, HDLG	Found it humiliating to have to bathe with girls of same age. Was frightened of Morag Jordan, who threatened and hit him. Considered discipline at HDLG generally appropriate for the time and did no harm but that Morag Jordan's behaviour was excessive. His face was rubbed in soiled mattress for bedwetting.	43
594	Read	1970s	HDLG, Off-island care	Describes spending a lot of his three-month stay in detention room. Says Superintendent was a bully who dragged him there with one hand round throat and other grabbing testicles. He describes Morag Jordan as “horrible” towards the children in her care.	59
599	Read	1970s	HDLG, La Preference	Describes time at HDLG as “pretty enjoyable”. Did not experience any mistreatment. Recalls Morag Jordan being “pretty hard on kids”. Says he was only punished when he deserved it.	46
802	Read	1970s	Foster care	Recalls being sexually assaulted by visitor to the Home and by a neighbour. As an adult, she met a Police officer whom she identified as the visitor who had assaulted her. She made complaints about both incidents, which were investigated, but no charges were brought.	139

643	Read	1970s	HDLG	Evidence provided by parent (WN395), as WN643 now deceased. During WN643's stay at HDLG, she told WN395 she was being sexually abused by a male member of staff at bedtime. Described him fondling her under bedcovers. WN395 recalls going to HDLG and reporting matter to person in charge but being told “no-one at the Home was capable of doing such things” and that WN643 must be lying.	48
36	Read	1970s–1980s	FGH, Foster care, HDLG, Heathfield	In his different placements, decisions were made about his living situation in which he had no involvement. This meant he was returned to an abusive home situation for visits and stays. At HDLG, was placed in detention for a period of around 36 hours, with no contact, aged nine. Describes a staff group with little understanding of how to care for children or meet their needs. Recalls one member of staff who was kindly, and how much tiny signs of affection and care meant. Describes staff being quick to hit and physically punish children and children being served same meal repeatedly till they ate it all. Says there was no culture of encouragement or affection. Was sexually abused by an older boy and reported this to staff but nothing was done. Describes children being paraded around “like a cattle show” for potential foster carers visiting HDLG. He recalls that when Mario Lundy arrived he was very intimidating and adopted a heavy-handed and regimented approach. Towards the end of his time at HDLG, he felt things changed, staff who were more understanding arrived and there was a key worker system. He felt he was unprepared for life after care. After he left HDLG he was sexually exploited by the person designated his special carer. He felt his need for affection and his vulnerability had been exploited. The carer admitted what had happened and was allowed to resign and WN36 says he was dissuaded from taking matter to the police. His academic potential was not encouraged and his attempts at further education faltered through lack of support. He describes social work service as inept and not fit for purpose, with little or no focus on or insight about children it was caring for.	55
43	Read	1970s–1980s	Westaway Crèche,	Was in care from infancy. Record of his being dangled by ankles, upside down, from window of FGH. Record of WN43 being struck by	52

			FGH, HDLG	member of staff “in heat of moment”. Was placed in detention cell each night because of concern that he might behave inappropriately with other children.	
80	Read	1970s–1980s	La Preference, HDLG, Heathfield, Les Chênes	Says that, at HDLG, children were left to own devices. Only saw one member of staff administer corporal punishment here. He disliked Heathfield as he found it a confined space and never able to get away from the behaviour, including bullying, of other children. He described WN335 as “creepy”. He was deeply disturbed by encountering WN335 abusing a young person. Says that, on admission to Les Chênes, he was assaulted by a member of staff and thrown into a secure cell without any clothes and kept there several days. He describes one member of staff sneaking treats into him and treating him kindly. He found the regime at Les Chênes intrusive. He states his care experiences have robbed him of his confidence and ruined his life.	60
120	Read	1970s–1980s	HDLG, UK residential school	Describes physical, sexual and emotional abuse at HDLG. Staff, including Morag Jordan, said to be physically abusive. Describes serious sexual assaults. Members of staff often smelled of alcohol. Witness believes she was overmedicated and that contributed to poor educational achievements. Describes periods of isolation as punishment. On leaving care, she had little support and was vulnerable and soon ended in prison.	34
Darren Picot	In person	1970s–1980s	HDLG, FGH, Heathfield	Has no recollection of HDLG, as was very young when moved to FGH. Describes suffering years of physical and emotional abuse at hands of Maguires and being battered every day. Recounts being made to spend hours standing with nose against tree in garden, regardless of weather. Recollects suffering two fractures as result of physical ill treatment. Punishments he remembers include being force-fed custard till he was sick and having mouth washed out with soap and with Dettol. Respected all staff at Heathfield, apart from one member of staff who abused him sexually. Les Chênes was “a bit like a prison”. Describes being dragged by neck through school and put in secure unit, where he stayed for two weeks. Aged 18, he was told only help he could be given on leaving care was a ticket off the island.	25

John Le Boutillier	In person	1970s–1980s	HDLG, FGH x 2	Recollects having faced rubbed in sheets for bedwetting in first FGH. Describes being hit regularly by Alan and Jane Maguire, with hands and wooden spoon. Felt scared all the time.	27
99	Read	1970s–1980s	HDLG	Spent 14 years in care system. Describes children being left to their own devices much of the time, and no structured activities, apart from mealtimes, which were strictly policed. Caned regularly, on bare skin. One member of staff used to take him to bedroom and beat him for no apparent reason. Experienced periods in detention when staff would turn off the call bell. Not allowed visits from siblings. Was roughly restrained and assaulted by staff after incident on holiday trip and on a camping trip was put by staff into a waste pit along with another child. Was not allowed to see siblings when they left HDLG.	45
185	Read	1970s–1980s	Foster care, La Preference, HDLG	Was treated harshly by Morag Jordan. Had face rubbed in soiled sheets. Describes being force fed food she did not like, being made to run around naked for bedwetting and being frequently hit around the head. Describes a highly sexualised atmosphere which she says was encouraged by staff, including boy being encouraged to masturbate in front of girls.	43
248	Read	1970s–1980s	FGH	Had no complaints about treatment. Was never punished and never saw any other child mistreated. FGH was “a normal house”.	26
125	Read	1970s–1980s	Foster care, HDLG	Suffered breakdown of several foster placements. At HDLG, was physically abused by Tony Jordan, who held him down under water in swimming pool and also injured his arm by twisting it. Also describes Tony Jordan forcing him onto floor and causing him to suffer cracked ribs. Other physical abuse included having his face rubbed in soiled sheet after bedwetting, being thrown in patch of nettles. He recalls being sexually abused by male members and by female member of staff. Made allegations of being sexually abused by Jimmy Savile during a visit to HDLG. Spent several periods of time in detention and had supper withheld until superintendent intervened.	43

148	In person	1970s–1980s	HDLG. FGH	Spent most of her childhood in care, and no-one ever explained why she was there or what going to happen. Was cut off from contact with church community that was important to her. HDLG was a horrible place. She remembers lots of punishments, including her mouth being washed with soap, caning, and a five-day period in a detention room when aged only eight or nine. She was bullied severely. At the FGH, there was no love or affection. She was sexually abused by Les Hughes. She raised issue of abuse and believed that prompted her discharge from care without support. She was not equipped to cope on leaving care and her experiences have had lifelong implications for her wellbeing.	21
145	In person	1970s–1980s	BYD, Les Chênes	Describes BYD as a “brilliant place” run by “a genuinely nice lady”. Describes being locked in cell at Les Chênes overnight for around six weeks on admission. While he found the strict regime of Les Chênes preferable to his home environment, he describes the punishments as “outrageous”. Describes WN108 as a “hard man” who used to beat children till they bled. He found the violence akin to the violent home circumstances he had left. Describes Mario Lundy as “vicious and nasty” and recounts being thrown against walls and furniture by him. Remembers WN246 as “a control freak and a drunk” who often was drunk at work. He describes only one member of staff as kind and nurturing, treating residents with respect. Describes several incidents of physical abuse he experienced at hands of staff. Was discouraged from complaining about treatment because he says he saw a resident whose parent complained being severely beaten afterwards. Was given no support on leaving care and on getting into trouble was returned to Les Chênes, where he says he was severely beaten for letting the Home down. This spurred him to leave Jersey as soon as his recall was over. As an adult he found inaccuracies in his social services records. His experiences have made him a very protective parent but also left him with serious trust issues.	61
247	Read	1970s–1980s	FGH x 2	No complaint about treatment by Maguires. Was punished but never hit, and never saw any other child mistreated. Remembers positive times only and continued to have a close relationship with Maguires into adult life.	26

252	Read	1970s–1980s	HDLG. FGH	Describes Morag Jordan slapping children hard for talking at night in dormitory, causing children to wet themselves in fear. Describes Morag Jordan's “extreme … Victorian attitude” but thought HDLG was “not a dire place” compared with situation she had come from. At FGH Les Hughes behaving inappropriately with her and other children and warding off his sexual advances at a young age.	22
153	Read	1970s–1980s	HDLG, Sacré Coeur	Was sent to spend days at HDLG when there was no satisfactory home care. She remembers HDLG as a very dark place where the children seemed miserable. Also spent time at Sacré Coeur where she describes the atmosphere as “not pleasant” but was not mistreated. Her main concern was she was repeatedly returned to an abusive home environment. When she disclosed abuse to a police officer the situation was badly handled and nothing changed. She was bullied severely at school and after trying to run away and leave the island was sent to Les Chênes. She describes Les Chênes as “like prison” and “horrendous”. She was locked in a room and allowed no personal belongings. She describes the routine as “mundane” and is critical of the educational provision. Describes WN246 as having a drink problem and being unfit to look after children at times leading on one occasion to insufficient staff cover during an outdoor activity where WN153 suffered a serious injury for which treatment was not immediately sought. Recounts seeing Mario Lundy kick a child and throw him in secure unit. She mentions one member of staff whom she describes as “sleazy” who made inappropriate comments to her and a female member of staff she recalls pinching and punching her and other residents. She feels the emotionally abusive regime of Les Chênes has had the biggest impact on her, as it made her feel worthless and staff lacked care and compassion. No-one ever tried to find out why she was making suicide attempts and she and her family were discouraged from pursuing psychological help which she was only later able to obtain privately. She found the probation service follow-up “useless”. She also recounts her experiences trying to get help for her brother who was admitted to Les Chênes and the “appalling” treatment he received.	139

176	In person	1970s–1980s	BYD, HDLG, Foster care	HDLG was “very big and very scary.” Remembers three members of staff who were particularly kind and helpful. Describes some other staff as “unbelievably cruel”. Was sexually abused by a member of staff. Describes Morag Jordan as particularly cruel and emotionally abusive, humiliating children for bedwetting, striking, kicking and hair-pulling. Recalls she kicked him so hard for stealing food he was sick and says she rubbed his face in vomit. Describes Tony Jordan as “a bully”. Describes detention cell as like prison, and very lonely and isolating. Detention cell was used inappropriately, for minor misdemeanours. Describes being sexually abused by a member of staff while being searched. Describes being kicked and punched by WN7, whom he describes as a violent bully. Describes a highly sexualised atmosphere at HDLG, with sexual encounters between children common. Recollects seeing sexual assaults on female residents by older male residents. He was subject to sexual assault by older male resident. He says bullying by older children was common and that there was little oversight by staff. Was profoundly affected by Operation Rectangle investigation and by giving evidence in court.	51
182	Read	1970s–1980s	La Preference, BYD, HDLG	Describes HDLG as an institutionalised existence “with little love or care”. She reflects that staff were doing the best they could but most were unsuited for the work of caring for children. Her communication with family had to be read to staff. Recalls being stigmatised at school for living at HDLG and teachers assumed she was there for offending not protection and were unsympathetic. She felt she was given unreasonable choice of continuing at HDLG or going back to abusive family situation and that no child should have had to make such a decision alone. When she disclosed abuse by her parent, she was not believed. She felt her allegation was discounted because she was living at HDLG and that the Police were not sympathetic and emphasised the effects on her parent. She felt completely unsupported and alone and withdrew the allegation.	48

Edward Walton	In person	1970s–1980s	La Preference, HDLG, Les Chênes	Describes receiving a beating from a staff member at La Preference, being punched and kicked till he soiled himself. The incident left him terrified and nervous. Apart from the one member of staff, he found everything “quite laid back” at La Preference. He was only in HDLG for a few weeks before being transferred to Les Chênes. He had no concerns about his time at HDLG. He was beaten up by his older roommates on his first night at Les Chênes. He thought the education he received at Les Chênes was “brilliant”. Only eight children were resident at the time and classes were very small. He enjoyed the Merit Award system and concentrated on accumulating points. He felt staff had best interests of children at heart and discipline was fair. He received a lot of support from Mario Lundy to pursue sporting activities, at which he excelled. He describes him as “a diamond” and a caring paternal figure.	62
210	Read	1970s–1980s	HDLG, FGH	Recalls being admitted to HDLG on Christmas Eve and being separated from siblings. She was punished, by being placed in detention, for trying to see a sibling who was in another unit. Describes one member of staff as “lovely” but said Morag Jordan was “evil”. She describes physical and emotional abuse by Morag Jordan, including washing out her mouth with soap and striking her on face. She says she told her mother she was sexually assaulted by male at HDLG, but nothing was done. Did not experience abuse at FGH and generally had a better experience because she was working and relatively independent.	53
223	Read	1970s–1980s	Foster care, FGH, HDLG	Describes being physically and emotionally abused in FGH and warding off sexual advances by someone living there. Recalls being physically assaulted at HDLG, including being made to stand in nightclothes in front of other children and slapped. Spent frequent periods in detention, which her social worker noted was handled insensitively and expressed concern at the length of time for which WN223 was locked up and the unavailability of key to release her in an emergency on one occasion. WN223 said she was made to work in the kitchen and threatened with being locked in detention if she did not comply. WN223 self-harmed and also made a serious attempt at	49

				suicide while at HDLG. Believes experiences have profoundly affected her later life.	
311	Read	1970s–1980s	BYD, HDLG, FGH, Les Chênes	Describes HDLG as “a daunting place”. Describes being sexually assaulted by HDLG boys on camping trip while male member of staff looked on. Describes regime at Les Chênes as very strict but mostly fair, although she thought a few members of staff were bullies who did not know how to look after children. She has been strongly affected as an adult by her experiences in care. A member of HDLG staff visited her at Les Chênes and she describes how he subsequently behaved inappropriately with her.	49
316	Read	1970s–1980s	HDLG, FGH x2	Had positive experience with Maguires and was very happy in the FGH. Continued to receive support from Maguires after she left care. Was not mistreated and never saw any other child mistreated, although later in life another resident disclosed to WN316 that they had been abused by Alan Maguire.	26
380	Read	1970s–1980s	HDLG	Describes regimented routine. Children were always being moved between bedrooms to split up certain combinations of young people. Stayed in HDLG Monday to Friday and went home at weekends. Was caned once but felt it was a reasonable and deserved punishment. Says food was very good. Describes Morag Jordan as “stern”. Other staff members he recalls as “motherly” and “fatherly”. He states he never saw any children mistreated.	46
383	Read	1970s–1980s	HDLG	Found HDLG initially a sanctuary from home life and recalls happy times there, especially with WN7. Describes experiencing physical and emotional abuse from Tony and Morag Jordan, including being force fed a meal he disliked until he almost choked. Recounts being sexually abused by male member of staff. He says other staff were aware of the excessive force used by the Jordans but did not challenge them. He felt there was no one he could tell what was happening. Describes children being made to stand outside for long periods, in nightclothes, for talking in dormitories.	52

23	In person	1970s–1990s	FGH, BYD, Foster care, Heathfield	Describes grooming and sexual abuse over several years by Les Hughes at Clos de Sables. Also describes physical assaults by Les Hughes. Was moved to Heathfield after disclosure, without adequate support, and self-harmed.	20
382	Read	1970s–1980s	HDLG, Foster care	Remembers being locked in detention for three days on arrival, aged eight years old, and being terrified. He says there were good times and bad times at HDLG but, overall, it was not a nice place to grow up. His brother disappeared one day to be fostered and he was never told why. He deprecates the policy of putting children in need of protection with young offenders and says he arrived at HDLG innocent and left streetwise, knowing how to break into cars and steal. He remembers Morag Jordan as particularly cruel and another member of staff as nice. He was upset at the arbitrary way children were chosen for treats like holidays, which he felt should have been shared with all residents. He recalls he reported to a member of staff that two boys had disclosed to him they were being sexually abused by another resident. Recounts an occasion when someone molested him while he lay in bed. He felt it was “more of a scare tactic than a sexual act”. He says main form of punishment was being locked in detention cells which he describes as “like prison” and totally unsuitable for young children. He understood they were supposed to be used only in extreme circumstances but felt staff were lazy and used them as an easy option to confine children. Essentially arranged own foster care with the family of a friend. He declined help from social services on leaving care and managed to build a successful career.	139
387	Read	1970s–1980s	HDLG, Les Chênes	Was admitted to HDLG four times, each time for a short period. His memories of HDLG are good and he did not experience or see any mistreatment by staff. He recalls “everyone disliked” Morag Jordan. On arrival at Les Chênes, he was placed in secure cell for two weeks. Recounts an incident when he was handled with “unnecessary force” by a staff member, but, looking back, considers it may have been “reasonable” at the time. Later, he had a good relationship with this staff member.	46

616	Read	1970s–1980s	La Preference, HDLG, Heathfield, Off-island care	Recalls being physically punished for not eating food he did not like. Says he was made to stand outside if he did not finish meal, and was also punished by being hit. While at Heathfield, he was physically assaulted at school but says he was told not to pursue a complaint and he would not be believed.	55
617	Read	1970s–1980s	La Preference, HDLG, Les Chênes, Heathfield	Spent much of childhood in care system. Multiple admissions, with no clear plan or purpose. Alleges assault by WN7 at La Preference. First mentioned this to a child care worker in 1990s then made formal complaint in 2003, which was not upheld. Describes punitive atmosphere at Les Chênes and being assaulted by WN68. Describes aggressive and bullying behaviour by staff at Les Chênes and describes WN246 as “alcoholic”. Says of Les Chênes “life was very hard there”.	55
673	In person	1970s–1980s	BYD, HDLG, Les Chênes	Describes the staff at BYD as “fantastic”. Only spent a short period in HDLG and can only remember being made to walk round outside in his pyjamas. Was not allowed home for first six months of his stay at Les Chênes. Spent first two weeks sleeping in secure unit. Says some of the staff were “fantastic” and others were “violent bullies”. He says the positives of Les Chênes were negated by the violence and bullying he suffered there, particularly from WN246, whom he says was “a thug and a bully” and frequently smelled of alcohol, and Mario Lundy, whom he recalls pinning him to a wall. He describes physical violence and emotional abuse. As an adult, he can see some benefits from the discipline and regime at Les Chênes but questions why some staff had to resort to violence and bullying.	63

31	In person	1970s–1990s	BYD, Foster care	Enjoyed short time at BYD. Believes family were pressured into releasing her to be fostered. Experienced emotional abuse from foster mother who drank heavily, made derisive comments about her birth family and used emotional blackmail to secure demonstrations of affection. Alleges one instance of inappropriate squeezing of breasts by foster mother. Most of her care provided by foster father. Witness never had any time alone with social workers and always saw them in presence of foster mother. Her experiences have affected her parenting as an adult. She has had positive experiences of a social worker as an adult and commends fact that social worker has built separate relationship with her child and spends time alone with them.	13
50	Read	1970s–1990s	HDLG	Describes a physically abusive regime with harsh punishments and ill treatment of boys and girls. Children punished and humiliated for bedwetting. Children left distressed in detention room. Husband of a staff member involved in altercation with child allowed to visit child in detention and assault him. Harsh physical punishments occurred even when children on holiday with staff. Describes sexual assaults on other girls by boys at the Home.	45
803	Read	1970s–1990s	Foster care, Adoptive care, HDLG, Heathfield	Has no complaint about any care homes. Describes extensive physical abuse, severe neglect and sexually inappropriate behaviour by adoptive father. Her experiences have left her emotionally traumatised and feeling she is never good enough and impacted on her adult relationships. She felt abandoned and unwanted most of her life. She feels strongly that better vetting of people with whom children are placed is crucial.	139

901	Read	1970s–1990s	HDLG, Foster care, Adoptive care, Heathfield	Describes years of cruel physical and emotional abuse by foster/adoptive father, including constant beatings, being stabbed with fork for putting elbows on table and, aged five or six, being made to watch all her favourite toys being burned. Recalls being locked in garage for prolonged periods. Describes sexually inappropriate behaviour by foster father. Was put outside in nightclothes in freezing weather and also thrown out of house on night before school exams. Subsequently had a short positive period of care with another foster carer. Believes inadequate checks were done on her foster/adoptive father because of his position and that his alcohol problems were known when he was approved to foster her. Experiences with him have had profound effect on her confidence and relationships as an adult.	139
3	Read	1980s	HDLG, Foster care, La Preference	In HDLG had mouth washed by soap and was physically punished. Experienced emotional abuse from a “very strict and mentally cruel” foster carer who repeatedly denigrated her. Carer's child sexually assaulted her and told her that she was not loved.	59
142	Read	1980s	HDLG	Remembers HDLG as being “strict and oppressive”. Aged around 12, was given responsibility of looking after a very young child with particular needs. He felt this was inappropriate and abusive.	49
Tina Maguire	In person	1980s	HDLG, Boarded out with family member	Was initially in care of family member who was harsh and emotionally abusive. No seeming oversight by Children's Services and any contact focused on adult's needs rather than child's needs. At HDLG, Morag Jordan made her life a misery. Witness was never able to talk alone with social worker who tended to talk to the Jordans. Describes being sexually assaulted by Jim Thomson when she went to clean his rooms at HDLG, and being physically assaulted by Tony Jordan. Inspections of home were pre-arranged and children warned not to talk to visitors.	47
88	Read	1980s	FGH, Foster care	Blanche Pierre “seemed like hell”. Harsh physical chastisement from Alan Maguire with spoon and slipper, including on bare skin, and had mouth washed with soap. Was force fed by Alan Maguire, in presence of Jane Maguire, when failed to clear plate at mealtime. Recalls being made to stand by front door for long periods of time at night for chatting in bedroom.	28

143	Read	1980s	HDLG	Describes being sexually assaulted by a male member of staff. Describes staff, particularly Morag Jordan, as terrifying.	49
173	Read	1980s	HDLG	Describes HDLG as initially “picturesque”. Was roughly handled and verbally abused by staff as he was put in detention after he objected to other children using video player his parent had given him. He describes being sexually assaulted while he was in detention cell.	49
199	Read	1980s	FGH	Hit very hard across head by Alan Maguire for least misdemeanour. Severe beatings from Alan Maguire using fists, hands and belt on bare skin, always on areas that were not visible. Had mouth washed out with soap and brush three times. Told a child care officer but says he was told to stop misbehaving and then he would not be punished. Describes disturbing Alan Maguire naked on a young female resident's bed and being assaulted by him.	28
203	Read	1980s	FGH	Gave statement to SOJP when aged 10, describing five sexual assaults by Les Hughes starting when she was eight years old. Recounted how he threatened to hurt her mum if she told anyone about what was happening.	23
216	Read	1980s	HDLG, Heathfield	Describes being sexually abused by a staff member (WN335) in whom he had confided uncertainties about his sexuality. Was forced to perform sex acts on his abuser and initially told no-one as he knew he would not be believed. After leaving care, he returned to work at Heathfield and continued to be exploited by WN335, including in his work environment. He eventually reported abuse when he thought another vulnerable young person was being groomed by WN335. He felt particularly betrayed, as the care system was supposed to offer him safety after early abusive experiences.	60
392	Read	1980s	HDLG	Recalls being in care for around three months and spending the entire time in detention cell, although she was allowed to attend school. Describes being subjected to intimate examination at the police station in the presence of a male social worker. She found staff at HDLG nice, including Jane Maguire.	51

590	Read	1980s	HDLG	Had personal items of sentimental value removed by staff. Found some staff “very kind”. Was once taken back late by family member she was visiting and was stripped and placed in detention room. Describes Morag Jordan as horrible and bullying though was never physically harmed by her.	43
William Dubois	Read in anon., then gave public evidence	1980s	HDLG, La Preference, Heathfield, Les Chênes	Was physically assaulted by Tony Jordan, including being punched in solar plexus on three or four occasions and being slapped across the face. Describes Tony Jordan as a bully. Describes being dragged around by the hair by Morag Jordan. Describes another member of staff, around time HDLG was closing down, hitting him so had he was knocked backwards against a wall and hurt. Same staff member dragged him out of bed and “knelt on my chest and slammed me about”. Physical abuse continued at La Preference, where a member of staff was always “thumping, slapping or grabbing me”. At HDLG, was slapped by member of staff who was treating his injuries when he had self-harmed. Was also hit and roughly manhandled at Les Chênes.	43 & 62
620	Read	1980s	Les Chênes	Describes getting on well with most of staff at Les Chênes, apart from WN246, whom he describes as “particularly aggressive” and prone to drinking. Recounts occasions when WN246 restrained him forcefully, including lying on top of him while pinning him to the floor. He first made a complaint to SOJP about his experiences at Les Chênes in 1999.	59
597	Read	1980s	HDLG	Describes HDLG as very regimented. Was introduced by other boys to sexual behaviour, smoking and drinking. Describes a sexualised atmosphere with older boys egging on younger boys to experiment with the girls. Describes being thrown in detention in a confined garment like a straightjacket. Describes being slapped on the head, pushed around and intimidated by staff. Believes his experiences have caused anxiety, low tolerance and claustrophobia in later life.	49

621	Read	1980s	Les Chênes	Describes Les Chênes as a “severe place” which made her “a nervous wreck”. Describes girls being locked in rooms at night to separate them from boys, and use of secure unit as a punishment. Recounts seeing a child physically assaulted by staff member and reporting this to magistrate who said it must have been deserved. Describes points system and loss of weekend leave for misbehaviour. Feels overall she was “quite well treated” but witnessed boys being physically assaulted by staff.	56
622	Read	1980s	Les Chênes	Had mixed experience at Les Chênes. Identifies some teachers as supportive and others, WN246, WN108 and Mario Lundy as “brutal” and bullies. Describes WN108 punching and kicking or stamping on him and throwing him against a wall and being punched by Mario Lundy. He says he was less concerned by the violence than by the fact that staff thought it appropriate to treat children this way. He recalls being caned till he cried and says children being smacked around the head and belittled was a routine occurrence. Describes sleeping in secure unit for first two weeks, aged 13, which seemed normal at the time but he now sees as unacceptable. Describes incident when WN246 was driving minibus with children while drunk.	56 and 139
625	Read	1980s	Les Chênes	Witness says he thrived at Les Chênes and that the education was “fantastic”. Describes the staff as “all brilliant, very committed”. He enjoyed the merit award system and succeeded in it. His only criticism was of WN246, whom he describes as “angry” and displaying problems with alcohol.	56
626	Read	1980s	Les Chênes	Did not witness any abuse at Les Chênes, although saw other children being restrained. Describes how weekend leave could be lost through merit system. She said she was an academic child and thrived at Les Chênes. She describes the staff as “great”.	56

623	In person	1980s	Les Chênes	Was admitted at parent's request, on voluntary basis, and was told by WN108 that she could leave but that, if she did, he would “bring her back under a court order”. Has subsequently discovered offences for which she was not responsible and with which she was never charged were attributed to her and used to justify her stay at HDLG. She describes the regime as “brutal” and says nothing was done to help her address any issues she had. She describes violence towards boys, specifically by Mario Lundy whom she says she saw hitting, pulling, dragging, whacking and bullying boys, but says girls were never physically harmed. She describes a member of staff who was particularly kind and with whom all the residents wanted to work, but also recollects WN246 whom she says “often smelled of alcohol” and behaved in sexually inappropriate ways towards female residents. She describes use of the points system to stop children having family contact as emotional abuse. She remembers a holiday to Snowdonia with staff from Les Chênes as a good experience. She felt isolated while in Les Chênes and saw her child care officer only once. She felt there was no adult she could approach.	64

624	In person	1980s	Les Chênes	Found admission terrifying process and was frightened by being locked in room at night. Describes not being allowed to have any personal belongings. Commends the education at Les Chênes, which enabled her to secure qualifications. Describes WN108 as “one of the nicest people you could meet” and a very good teacher, though he would shout and scream at girls if they misbehaved and she was aware he used physical punishment on boys who she saw emerge from his room with bruises and black eyes. Describes Mario Lundy as a very good teacher who could be “very nasty” and pushed boys against walls. Describes WN246 as “nasty and always drunk” and “sleazy”. She recalls one particularly kind member of staff. She disliked the points system as she felt it pitted the children against each other. Recalls being dragged out of showers and humiliated by member of staff for bedwetting. She felt the positives of Les Chênes were outweighed by “the violence, bullying and emotional manipulation” and that staff made children feel worthless. She says she recalls no involvement of Children's Services at Les Chênes and no support from them on leaving care.	63
633	Read	1980s	La Preference, Heathfield	Recounts an incident while on a camping trip, where he saw WN662 fiercely smack a child and when he and others protested WN662 chased them. Also describes being kicked by WN662, who also attempted to hit him with tennis racquet. Recounts being sexually abused while in bed by an unknown male, whom he presumes was a member of staff.	60
651	Read	1980s	Les Chênes	Describes a “physically and mentally abusive” regime. Recounts being put in isolation for two weeks on admission “to acclimatise”, which left him scared and lonely. Describes series of physical and emotional abuses at Les Chênes and sporting activities being used by staff member as opportunity to kick and punch boys. Recounts occasion when WN108 grabbed and threw him against a cabinet and a wall and that he was physically assaulted by another staff member. Describes being humiliated because of enuresis by an “evil and sadistic” member of staff. He acknowledges there were three supportive members of staff but describes WN246 as “an aggressive alcoholic” who crashed a vehicle transporting children while he was drunk.	59

81	Read	1980s–1990s	FGH, Foster care, La Preference	Mouth washed out with soap, made to stand for long periods at night for having chatted in bedroom. Force fed food. Describes being physically punished, hit with spoon by Alan Maguire. Was fostered and then rejected by the Maguires and describes Jane Maguire ignoring her and pretending not to recognise her.	30
251	Read	1980s–1990s	HDLG, FGH, Les Chênes, La Preference	Describes HDLG as strict and regimented. Recalls being dragged by hair by staff member and locked in a room with no access to toilet for many hours. Describes Les Hughes as “touchy-feely” but experienced no abuse. Believes a psychologist made a recommendation she should not be at Les Chênes but that this was ignored. Did not suffer abuse at Les Chênes but recounts incident she witnessed involving staff and a young male resident. Had no complaints about La Preference.	22
250	Read	1980s–1990s	HDLG, FGH, Les Chênes, Heathfield	Was aware of Les Hughes’ inappropriate attention but he never assaulted her. Did not experience abuse at Les Chênes or Heathfield but recounts incidents she witnessed involving other children.	22

780	In person	1980s	Les Chênes	Was never told how long he was to remain at Les Chênes – in the event, it was over three years. On admission he was placed in secure unit, which he describes as dark and frightening, and he recalls crying through night. He was not allowed home for the first three months of his stay. He describes Les Chênes as sports oriented and thought favour was shown to young people like him who excelled at sports. He was able to use the merit system to gain regular home leave. He thought the points system a good discipline tool but felt it unfair to link it to home leave and also felt it was unfair on children with learning or behavioural difficulties who would be regularly penalised. He describes the staff controlling the environment through physical violence. He says canings were particularly severe. Describes bullying of weaker residents by other residents and being subjected to racial abuse from both staff and residents. He says children were physically and emotionally abused on a daily basis. He describes being picked up and thrown against walls by WN108 and Mario Lundy. Also recounts violent football games played between staff and residents where he thought staff used the opportunity to assault boys. Describes them as the roughest games of football he ever played. He describes WN246 as “particularly abusive” and rough handling children. He describes incidents he witnessed of WN246 being physically abusive. He states WN108 punched him in the stomach after he stole money from Les Chênes. He commends the educational discipline at Les Chênes, which helped him secure qualifications.	114

76	In person	1980s–1990s	Foster care, FGH, Heathfield	Moved around several foster homes before FGH. Lived in constant fear, always on edge because of punishments or Jane Maguire's threats of punishment. Was force fed. Made to stand in freezing cold by door and was also severely physically punished for bedwetting. No medical attention sought for enuresis or for an injury. Regularly beaten with wooden spoon. Describes being sexually assaulted over period of time by Alan Maguire. The Maguires discouraged her family from visiting by claiming falsely that it made her upset. Effect of maltreatment was to make her unable to accept the nurturing situation she was moved to. She self-harmed and overdosed. Was later reallocated flat in Blanche Pierre building and had flashbacks to abuse.	29
154	Read	1980s–1990s	FGH	Recalls strictness, children hit with spoon for talking at mealtimes, and lived "in a climate of fear". Physically assaulted and punished by Alan Maguire, including having mouth washed with soap and being made to stand for hours. Looked after children had old clothes and toys in contrast to the Maguires' own child. The Maguires constantly humiliated children. Adult family members and friends made representations to Children's Services about mistreatment at FGH but these were dismissed. He eventually ran away to the home of a staff member and made a complaint to a children's officer about mistreatment.	27
4	Parent gave evidence	1990s	Aviemore – respite care.	Evidence given by father (WN47). WN4 has a disability. Disclosed to parent that he had been sexually assaulted and had seen another young person sexually assaulted by a member of staff, while at Aviemore for respite care. Family concerned that no separate child protection investigation undertaken by Children's Services, even though there was no prosecution, and member of staff still working with vulnerable people.	64
52	Read	1990s	Les Chênes	School aware of allegations that WN52 was being bullied and assaulted. Family was concerned about bruising on visits home. Family complaint about Les Chênes became a complaint about family to Children's Services by Les Chênes.	139

73	In person	1990s–2000s	Heathfield, Les Chênes, La Preference, Greenfields	Spent first night in Les Chênes in bare cell, with only a mat to sleep on. Spent long periods in secure unit which he described as extremely traumatic and self-harmed while there. Describes Les Chênes as full of young people stuck in an endless cycle of offending, release, and remand. Describes insufficient staffing leading to children being kept in secure rooms too long and no attempt by staff to understand or treat underlying problems that were leading to offending and absconding behaviours. Spent time in La Moye, which he found more constructive before returning to care system. Aged 16, he was living in a bedsit and attending school. He felt care system had washed its hands of him. Evidence was also given by a family member (WN65, Day 57) about efforts to secure appropriate care for WN73, adverse impact of solitary confinement on him and failures of professionals to include family in discussions and decision-making.	56
698	Read	1990s–2000s	Foster care, La Preference, Heathfield, Les Chênes	First foster care placement was very happy and loving. At second placement she was abused by the son of the family. After she disclosed this to a relative, she was moved to La Preference which she found was safe but strict “with no real love or care”. Another foster care placement was initially nurturing and she was happy but after foster carer admitted striking her she was moved twice more to foster homes before she was admitted to Heathfield. She felt her disrupted placements had a traumatic effect on her. She says she was a well-behaved child whom people kept letting down. At Heathfield she was sexually abused by older residents and also by a member of staff. She describes another member of staff who supplied residents with drugs and who sexually assaulted her. She also recounts being sexually assaulted outside the Home by someone who supplied drugs. She says she was physically assaulted by a staff member at Les Chênes and spent a lot of time in the secure unit. Describes a rat's nest being found in her bedroom by visitors. She praises the professionalism of her social worker who was a consistent and caring presence throughout her adolescence.	65

618	Read	2000s	La Preference	Describes an incident at La Preference involving WN7, whom he says threw him against couch and caused him to hit his head against a window. Incident came to light because a child who witnessed it mentioned it to staff member at another establishment who raised the matter. Children did not complain because they assumed they would not be believed.	55
627	Read	2000s	Les Chênes	Was placed in secure unit on arrival, aged 13, made to wear PE kit and no shoes and being allowed out only one hour a day for exercise. When he absconded he was returned to the secure unit. He describes being restrained by a member of staff and also incidents involving a male member of staff about whom he complained after being grabbed by the testicles. He describes his time at Les Chênes as “three years of hell”. He believes the amount of time he spent in isolation has affected his ability to go out now.	57
628	Read	2000s	La Preference, Heathfield, Les Chênes	Describes spending long periods of time in secure accommodation. Recounts being inappropriately restrained by staff member and having all his clothes removed one time he was in the secure cells.	57
629	Read	2000s	Les Chênes	Describes being placed in secure cell for first 24 hours. Recounts incident following absconding when she was roughly handled and had her head banged against wall by member of staff. Describes making complaint about male member of staff who she recalls used to come into bedroom to watch her and another female change. Recounts three occasions on which she saw children being roughly handled by staff.	57
630	Read	2000s	Les Chênes	Describes prison-like reception procedures, including strip search and placement in secure unit. Aged 12, he was younger than other residents and subjected to bullying. Describes being confined to secure unit for minor misdemeanours. Describes two incidents when he was roughly handled by staff, being pinned against a wall by a member of staff who smelled of alcohol and being dragged in a headlock by another staff member to detention cell. He says that after one staff member trained others in restraint techniques this approach was used gratuitously instead of attempts to de-escalate situations. Said his father complained about his prolonged periods in secure	57

				accommodation but nothing changed.	
749	Read	2000s	La Preference	Describes being dragged by hair and roughly handled by WN7, and pushed into a couch where she smacked her head. She recollects another member of staff suggesting she make a complaint about incident. Member of staff recorded that WN7 had used “unreasonable force” against WN749. Also describes being slapped by WN7.	61
752	Read	2000s	Heathfield	Describes being sexually abused by person outside Heathfield who had groomed her over many years, and that on one occasion when she was vulnerable and asked Heathfield staff to come and get her she was told they had insufficient staff and she had to walk back. When she disclosed later to staff what had happened, they alerted police. Police investigation revealed that abuser had been able to contact her by phone at Heathfield and collect her from there by car, unchallenged. WN752 later became pregnant following a relationship with a member of staff at Heathfield. The member of staff resigned and no further action was taken.	61

APPENDIX 3

Recommendations from Witnesses, and other Contributors to the Inquiry, on the Future of Child Care in Jersey

1. During the course of hearing evidence, we made a point of asking witnesses whether they had any recommendations that they would wish us to consider. Many witnesses gave their view on what needed to be done to ensure the safety and wellbeing of children and young people in Jersey for the future. In our Phase 3, we asked those we met and those who came to give evidence in public to make more specific recommendations. **We also invited recommendations from members of the public and from stakeholder organisations in Jersey**. A full list of contributors to Phase 3 is provided at Appendix 4.

2. In all, we have been able to gather 659 recommendations from these sources. We grouped these into 11 categories. Many of the recommendations overlap or are repeated and show consistency of view on many matters. We have used contributors' own words, as much as possible, and have usually copied exactly from written suggestions. Although some contributors helpfully presented extensive materials and context, we have presented the essence of their recommendations. The full context and supporting materials received in evidence and in consultation are available online.

3. We have presented the recommendations anonymously. We do not want the identity of any contributor to influence the regard or priority given to any recommendation. We consider that all the recommendations listed below are worthy of consideration, and many of them have informed the recommendations that we have made in our Report.

4. There are a small number of the recommendations made by witnesses that, after careful consideration, we do not feel able to support, or that we consider require some amendment. **These are discussed below, in the table of recommendations.** We have, however, taken the view that it is important to record all of the views of our witnesses and contributors.

REC No.	RECOMMENDATION
	Advocacy, Listening and Responding
1	Listen to young people.
2	Remain child focused. Ensure there are ways for the voice of the child to be heard.
3	Implement a comprehensive partnership strategy to achieve better outcomes for children and young people that enables the commissioning of the right services, ensuring resources are in the right place.
4	Have a dedicated team of people to hear concerns and be available to listen to children in residential care.
5	Have a participation structure for children and young people in place that may include a youth parliament, looked after children group, minority groups including children with SEND, and consultation generally – supporting service re-design, development and evaluation.
6	Ensure there is a separate body in place to talk with and listen to children.
7	Have a Youth Safeguarding Board – a panel for young people from a range of groups (youth clubs, committees, youth parliament etc) to discuss and debate on safeguarding issues for children and young people in Jersey – would allow young people to raise issues and ideas around safeguarding directly into the adult SPB.
8	Ensure there are advocacy services for children.
9	Introduce an independent off-island commissioner to champion the rights of children, enable the voice of children to be heard and hold the executive body to account.
10	Children and young people should be involved in all decisions which affect them.
11	Children and young people should be involved in all decisions made about them, particularly when it involves placement moves or contact arrangements.
12	Children must have an independent way of reporting their concerns and threats to their safety, ensuring that their rights are upheld.
13	Children should be listened to. “My whole life could have been so different …if someone had asked me what I wanted.”
14	Children should have access to someone they can trust – possibly someone who has lived through similar experiences.
15	Children should have decisions explained to them in ways they understand and to have any worries or disagreement they express recorded.
16	Children's Rights Officer.
17	Children's social worker should spend time alone with them. If they think something is upsetting child they should find out what is wrong.
18	Complaints process to be adapted to make it more child friendly and accessible.
19	Consider the Inspiring Voices project, which works with local authorities to strengthen the voice of young people and to encourage a broader range of young people with care experience to shape the design and delivery of services which impact on their lives.
20	Ensure there is effective scrutiny to ensure that children are heard – despite large numbers of adults involved in the individual's life, children often complain at not knowing what is going on and not being involved in the decision process.
21	Ensure the child or young person has a strong voice in all decisions which affect their care.

22	Ensure children's privacy is respected whilst balancing the health, safety and wellbeing risks – because they do not believe confidentiality respected, children often withholding information.
23	Ensure the voice of the child is heard.
24	Get to know children and their needs before placing them in care.
25	Give children a choice of who they speak to.
26	Listen to children and involving children in the design and delivery of services.
27	Important to have advocates for people with communication difficulties.
28	Important to hear the voice of the child.
29	Improve advocacy services for children and have an improved advocacy service for parents/carers.
30	Improve communications generally.
31	Independent advocacy that is provided separately from the state body that is responsible for the child's care is vital to ensure that children and young people are able to be kept safe and have their rights upheld.
32	Involve children in devising policies and decisions that affect them. An aspiration to embed emotional wellbeing as a priority in their lives.
33	A person or body who worked independently from the States could be appointed (like a prison board of visitors) to visit and gain the trust of those in care, so that those children would feel able to talk freely without fear or favour.
34	IVYP should not be denied access to children in secure accommodation.
35	Listen to children. “If people had been willing to take the time to listen and care, my story could so easily have been a very different story.”
36	Listen to children. “Children will talk to you if you show you believe them and you'll listen to them.”
37	Listen to parents. No-one feels more of a failure than a parent who needs help with their child, especially when it involves the care system and they don't need to feel condemned by the judgements of others.
38	Listen to the voices of parents, children and young people – and put them at the heart of service delivery.
39	Listen to what children and young people want and need.
40	Provide for advocates/independent visitors for looked after children to be enshrined in law.
41	Sensitivity is essential.
42	Show kindness to children.
43	Sit down with child and talk with them – do not make assumption that they are the problem.
44	Implement a system of advocacy for children – e.g. Children’s Commissioner or Children's Rights Officers.
45	Continue the “befriending role”, the confidential listening ear of IVYP, which is important to the looked after children.
46	Place the “family” at the heart of Jersey life and all our efforts to secure a community in which all islanders have a genuine voice – not just those with wealth.
47	Enable the child to have a voice, is listened to and supported consistently by a circle of adults around the child, with communication between the adults being both face-to-face and in writing.
48	Hear the voice of the child.
49	Truly listen to children in care, which will give children a feeling of power and control over their lives.
50	Understand and listen.
51	You have to listen to children.

	Early Intervention and Prevention
52	Offer all women ante natal contact in the home.
53	Implement an early intervention family-support function.
54	Provide both young people and parents with information at their fingertips regarding the services available to them in Jersey.
55	Children and young people need to build and maintain good, strong relationships with family, peers, teachers – if the input is right at a young age, then over time the costs to the island will lessen.
56	Children should spend childhood (three months to age 11) on same site being cared for and learning from range of professionals.
57	Continue and develop of the JWR, the only safe place on the island for women and children suffering from the effects of Domestic Violence.
58	Ensure dedicated provision for supporting women with poor perinatal health.
59	Develop family centres and bring Home Start charity to the island.
60	Early Help Approach demonstrates the positive effect multi-agency working can have at an earlier stage than a reactive response later down the line and should be used as a model going forward.
61	Identify needs early.
63	Excellent PSHE can hold the key to building resilient and informed young people.
64	The voice of the child is heard in early years policy.
65	Provide good quality information, early intervention and ongoing support linked to assessed need which strengthens families and enables them to meet their children's needs.
66	Put greater emphasis on early support and preventative services.
67	Ensure greater, proactive intervention from Children’s Services to support vulnerable children at an early stage.
68	Improve the dialogue with young people over their health issues.
69	Increase emphasis on early help and support services that families and children can access at any point in the child's life, and in places that are relevant to them, including schools and community settings as well as via healthcare services.
70	Increase funding to allow more availability of the Health Visiting service to minority group children and families.
71	Invest in intensive support to keep children at home wherever possible.
72	Jersey to aim to lead the way on supporting parents e.g. training and using parents to help other parents.
73	Manage and staff nursery units with child care professionals, units to open all day, catering for working parents.
74	MECSH programme for women to access dedicated support in the home to be available to the universal caseload.
75	Minimise the number of children who come into care by strengthening families to meet their children's needs.
76	Ensure a more focused and co-ordinated multi-disciplinary approach to health care of minority groups and specific training for nursing/health visiting staff working in this area.
77	Ensure a more robust provision of health care for diverse and minority groups within the island's community.
78	Implement more supportive, systemic approaches for the whole family.
79	Move from giving parents a voice to making them part of the solution.
80	Use multi-agency chronologies in recording and include chronological reports from schools and nurseries in order to give a systemic overview of a child in a family their world and experience.

81	Ensure that Preventative Early Help is readily available and adequately resourced so that it can address concerns.
82	Promote healthy, active lives and ensure opportunities to take part in sport and active recreation.
83	Provide children, young people and their families with early intervention and preventative services will ultimately secure benefits in the long run.
84	Pupils need to be taught skills that help them manage challenges and situations in that they may face now and in their future.
85	Develop the health visiting service and increase staff numbers.
86	The island does much in education with “Prison Me No Way” and “Expect Respect” and PSHE programmes, but more is needed if we are to increase understanding of what is available to help families.
87	Urgently develop early intervention family support (tier 2) services as a key component of a wider Early Intervention and Parenting Strategy.
88	Involve young people in what PSHE looks like going forward in schools in Jersey.
	Experience of Being Looked After/Aftercare for Care Leavers
89	Ensure 24/7 access to CAMHS to avoid overnight/weekend admissions.
90	Ensure a continuum between care and family support with greater use of more flexible support.
91	Carry out a feasibility study investigating the provision for the care of looked-after children to stay on-island.
92	As a good parent would not expect their child to move out on their 18th birthday – in fact a good parent would support their child and let them return to the family home when they need to and Jersey must ensure that it does not leave its most vulnerable children to live without direct support from their “parent” at a much earlier age than most other young people.
93	Provide a secure and stable environment where children can stay long term and have stability and stay in Jersey if that is their wish, rather than be moved off island
94	Ensure a united decision-making process with best interest of the child being paramount.
95	Address the lack of continuity of adults in children's lives due to too many bank staff, frequent changes in staff, changes in social workers.
96	Provide adequate aftercare services needed for victims of abuse.
97	Adopt Action for Children Residential Outcomes Now model/Ealing Brighter Futures – one person staying with young person through care journey/North Yorkshire “No wrong door” – services adjust rather than child move.
98	Action for Children intensive foster care models. Focus on stable, high quality relationships. Use specialist looked after children wellbeing measures.
99	Ensure an individual development and improvement plan for each child.
100	Any child in secure accommodation to be seen by a CAMHS specialist.
101	Make appropriate places of safety available for children so no child spends night in custody and so that mental health needs of children requiring place of safety are provided for.
102	Provide appropriate therapeutic support to enable children to deal with their issues and aspire to achieve the same things of children who are not looked after children.
103	Avoid out of jurisdiction placements for looked after children wherever possible and when they do have to happen, ensure strong relationships are built between social workers/teachers on Jersey and off-island, and have in

	place a local independent visitor/advocate for that child.
104	Avoid splitting sibling groups.
105	Be fair between all looked after children within reason.
106	Be honest with young people about what is happening and why.
107	Be more sympathetic to moods of kids (residential care).
108	Ensure better communication between Children's Service managers and Residential Child Care Officers with involvement in decision making concerning the looked after children they care for.
109	Build relationship-based models to encourage the positive relationships that are fundamental for children and young people in care.
110	Homes for children should be a “home” – Brig-Y-Don is an institution with offices/attached flats – they have to be units that mirror ordinary family life.
111	Brig-Y-Don should not accept food donations from M&S, giving children the message that they are charity cases.
112	Caring.
113	Children coming into care should be seen by a psychologist and assessed and early intervention commenced where needed.
114	Children in care should have access to a range of mental health therapies, available whenever they need them, and for as long as they need them and support should not be time limited, particularly as young people in care system may take long time to build trust.
115	Children must be kept safe – not bullied or assaulted.
116	Children need to know they are loved. “They just need love.”
117	Children should be placed with families rather than in institutions. When something goes wrong the children's lives should be stabilised quickly. Children should not be moved from pillar to post.
118	Children should be treated well in care.
119	Children should know what to expect – or they think what they are experiencing is normal.
120	Children should not be made to feel like prisoners. More emphasis should be on reasons children need to come into care, on what has happened to them.
121	Children should not stand out as looked after children.
122	Children should be cared for by qualified people in a safe environment.
123	Children should be kept safe whatever the cost.
124	Children should be made aware what to expect from care, what should not happen and what to do and where to go with concerns and complaints.
125	Children should feel loved, nurtured and have a sense of permanence.
126	Change the fact that Children's Homes are confusing because staff change and go off duty.
127	Children's Services and allied agencies in Jersey must provide a seamless, well-signposted service to looked after children/young people.
128	Communicate better between staff and kids.
129	Consider additional hours for the LAC nurse role in order to meet the service demand.
130	Consistency is vital.
131	Ensure consistent, stable, loving relationships – they are the “golden thread” and are more important than specialist services.
132	Ensure that contact is meaningful – these are childhood memories that are being made.
133	Ensure continuity of people looking after children – it is important.
134	Co-ordinate the large amounts of multi-agency information and ensure that looked after children’s immediate carers are fully appraised of matters concerning the children and involved in the decision making.

135	Make counselling and emotional support as the norm rather than exception for Looked After Children.
136	Develop options to remain in care post-16 in residential or supported accommodation “Staying Put” arrangements to be created to allow young people in foster care to continue living with their foster family up to tor beyond the age of 21.
137	Develop the evidence base of what works in residential care and use the evidence base on the effectiveness of residential interventions, and on more “therapeutic” forms of residential care, by agencies such as Action for Children, to inform plans and developments in residential care in Jersey.
138	Enable young person to move into the world, fully supported and with best experiences possible provided. Children to be able to stay in care setting beyond 18 if needed.
139	Provide enough resources to meet individual children’s needs.
140	Ensure psychological support can be accessed by survivors of care home abuse in years to come.
141	Ensure that children whose needs cannot be met by their parents are identified and have their needs met in a care environment which, wherever possible, is in a family context.
142	Establish a system which allows close relationships to be forged between school and a care home when a young person is taken into care or changes school e.g. primary to secondary.
143	Extend the age when young people are “prepared” for leaving care because young people in care from an abusive and/or neglected background are not' emotionally or mentally ready at 16 years to be “left alone”. It has a devastating effect on their sense of belonging and sense of security without having the comfort of knowing someone Is there for them.
144	Extend option of “Staying Put” to children living in residential care to offer them the same sense of security and an equal chance to properly prepare for independence as a young adult.
145	Provide follow-up and support once a child leaves care. Have half-way houses to help them become independent with one-to-one support from staff.
146	Residential care should be second to none, not second class to everything else the States provides – these children deserve the best and more, it Is not their fault they are there and so they shouldn't be treated as though they don't deserve any better.
147	Fully implement a system similar to England’s Quality Standards.
148	Getting along with the child (in residential care).
149	Get better with who is appointed (as residential staff).
150	Have time with child alone.
151	Provide help for young people leaving care to prevent large number of suicides.
152	Invest in children beyond age 18 – as long as determined by individual assessment.
153	Invest in good accommodation for young people leaving care.
154	Independent Reviewing Officer should be truly independent of line management and advocate for children in review process.
155	Do not see it as an inevitability that bad things will happen while in residential care.
156	Understand that just because I don’t live at home anymore doesn’t mean what happened doesn’t still affect me.
157	Keep children from ethnic groups in touch with language and culture.
158	Keep children informed of what is happening to them and how long it will be for. Children need to have a sense of belonging and their identity affirmed.

159	Keep consistent.
160	Looked after children should be fast-tracked for dental care.
161	Implement leaving care legislation.
162	Listen. Communicate. Care.
163	Give looked after/fostered children emotional support and counselling from an early stage.
164	Provide looked after children with specialised education programmes, delivered differently, including encouragement to participate in the arts.
165	Provide low level mental health and emotional wellbeing support, through mentoring schemes and other ways to maintain and build resilience and learn coping strategies.
166	Make sure that every day of the week, what the child needs is being met.
167	Provide a mentoring system for children – using independent people.
168	Provide one to one sessions with houseparent's to see how child is faring and what could be done to make their life better.
169	Please be consistent with my care.
170	Promote attachment, resilience and self-esteem for children and young people who are looked after by improving access to a range of coordinated services.
171	Reassess the way older young people (above 16) are considered capable of making their own decisions, given rights of confidentiality etc. Young people with a background of abuse and neglect remain very vulnerable and are not always capable of processing situations and assessing risks the way other teenagers" that age would.
172	Records should reflect the child's personality as they may be all child has left of childhood.
173	Residential care homes should have same ethos as hospice – where every decision, every issue is dealt with from perspective of what is best for the patient.
174	Instigate a review of care homes and their systems to provide effective support in ensuring youngsters attend school and maintain a high attendance.
175	Do not use solitary confinement in secure accommodation, which is abusive.
176	Support to be put in place to help young people in the care system into adult life, recognising their difficulties will affect them for a long time.
177	Address the lack of, and poor keeping of records – they are important to people who have been in care, yet it was hard for some survivors to obtain theirs and then not always complete.
178	Children must be placed with their brothers and sisters and where this is not possible or appropriate, contact between siblings should be maintained, supported and promoted. The relationships children in care have with their siblings can be the only life long relationship they have with a birth family member and wherever possible, and in their best interests.
179	Understand the very real issues facing children in care homes. Children have been exposed to alcohol, drugs, violence and inappropriate behaviours by others, and had the police called out while there. This is supposed to be a 'home' where protected from such things not exposed to them.
180	Ensure young people have enough time to spend with the professionals who work with them.
	Judiciary and Justice System
181	Ensure faster resolutions – "The court proceedings often took so long that planning for permanence nearly died a death when you had a case going on for two years within the criminal court."
182	Ensure that all Achieving Best Evidence interviews are undertaken in the

	presence of an intermediary or a suitably qualified child psychologist, and that appropriate provision for this is made by the Ministry of Justice and police forces.
183	CAVA should consider whether all agencies involved in the criminal justice and the civil justice systems are giving due consideration to the needs of children and vulnerable people.
184	Centeniers should relinquish charging role in court system.
185	Closer links with Court judges re cases and in care proceedings (PLO).
186	Consider if there should be changes to court rules to assist child and vulnerable witnesses participating in the court process.
187	Consider whether the jurisdiction of the Youth Court should be increased.
188	Court should change approach of favouring rights of the parent rather than the child. Courts should not make decisions about whether a child should be removed from parental care dependent on the geography of the proposed placement, as this could be interpreted as the location of the child overriding the protection of the child.
189	Courts should become more child centred in proceedings and have a focus on the rights of the child.
190	Develop an effective programme for identified young people who were NEET, possibly through the re-establishment of a Jersey Youth Action Team (YAT).
191	Ensure that children who are remanded in custody have access to a Guardian in the same way as other children subject to public law proceedings.
192	Island needs a fully independent prosecution service.
193	Consider reopening the Maguire case.
194	Members of the Judiciary should have better training and awareness in child protection, and of the link between abuse and offending.
195	Change the mindset of the judiciary – they are not child care experts and so should listen to those who are.
196	Recognise that the right to Bail for children is especially important and require Social Services to make provision if a child cannot return to family or friends pre-sentence.
197	Remove “old style” committal hearing provision.
198	Resolve the difficult legal issues around children's privacy and rights when they are co-accused with adults and when they are required to appear before the Royal Court.
199	Review the dismantling of the Youth Action Team.
200	Make the court system more child friendly in terms of vulnerable witnesses giving evidence.
201	The Honorary Police hold no place in Jersey in the 21st Century and should not be involved in matters of abuse.
202	Implement training for judges and advocates in child protection issues.
	Legislative Framework
203	Article 1 of UNCRC to be foundation of all law, strategies and response to children.
204	Enshrine in law better protection for whistleblowers.
205	Ensure better staffing of Law Draughtsman Office.
206	Bring the nursery classes under the Day Care of Children Law (Jersey) 2002.
207	Change the law in relation to police caution and adverse inference.
208	Consider legislation to compel the whole system work together by setting out in legislation the roles of named person and lead professional.
209	Consider the evidence from other jurisdictions in relation to the mandatory reporting of suspicions of child abuse.
210	Ensure that the Regulation of Care Act has sufficient proposals for children

	services including arrangements for the Inspection of services to children in Jersey.
211	Insert a statement into the Criminal Justice (Young Offenders) (Jersey) Law 2014 recognising that the welfare of children should be a paramount consideration.
212	Insert a statement into the Criminal Justice (Young Offenders) (Jersey) Law 2014 recognising that the welfare of children should be a paramount consideration.
213	Ensure that Jersey law keeps pace with new developments in IT e.g. offences of possession of images of children.
214	Bring Jersey into line with other jurisdictions on corroboration requirement and adverse inference.
215	Jersey to have in place the means to enact new legislation promptly. Sufficient funding and time for law-drafting.
216	Legislation needed to ensure looked after children supported by States into their twenties – as long as they need.
217	Legislation to give SOJP conditional bail powers.
218	Mandatory reporting legislation.
219	Mandatory reporting of abuse by child care professionals.
220	More people to be available for drafting legislation and to be trained in children's law. Each department to have an officer responsible for policy development and drafting instructions.
221	Need a statutory basis for working with children in need.
222	New sexual offences legislation.
223	No old-style committals in cases involving sexual offences.
224	Paramountcy principle at heart of everything.
225	Police to be given power to question suspect after a charge is brought.
226	Prioritise the development of justice policy and legislation – significant progress is now being made in this area – and of family policy and legislation.
227	Raising the age of criminal responsibility from 10 years of age.
228	Safeguarding on a statutory footing.
229	Separation of powers to ensure operational independence of SOJP.
230	SOJP officers should have the power to charge, particularly in relation to offences of child abuse.
231	Specialist legal advisor for children's social work advising on day to day application of the law.
232	Statutory requirement for auditing and inspection.
233	The Child and Vulnerable Adult Policy Group (CAVA) should explore how to strengthen the statutory responsibilities of organisations and professionals working with children, as part of their duty of care to children and young people, to ensure that all professionals work together more effectively to identify abuse.
	Political Priorities, Policies, Structures
234	Anticipate and prepare for the challenges which will face children in the coming decade e.g. different forms of media exposing them to different risks.
235	Residential care not seen as last resort; recruitment of qualified and highly skilled professionals.
236	A Children's Minister or Ombudsman.
237	A Children's Minister to ensure a top-level joined -up approach to children's services.
238	A Children's Minister would not be successful with the present system of collective responsibility with the Council of Ministers we now have, it would be a very hard and difficult task to get measures in place that are as strong and

	forceful as we probably require.
239	A coherent, visible, partnership strategic framework focused on all children and young people's outcomes with priorities arising from this strategy based on needs analysis.
240	A focus on evidence based approaches to working with families.
241	A Jersey Youth Board – to discuss issues affecting young people in Jersey – Similar to the Youth Parliament, it could be more frequent and more informal.
242	A robust active strategy with shared priorities, target outcomes, roles responsibilities, actions and agreed timescales using co-ordinated approach by officers at a senior level or otherwise to use multi-agency strategic planning to drive improvement and increase positive outcomes for Jersey's children.
243	A single point of contact for each student would be beneficial to ensure consistency and developing relationships between schools, key workers and students in care.
244	A statement enshrined in law that the principle aim of the care system for children and young people who spend significant time in care is to achieve recovery and healing from past harm.
245	A strategic plan setting out what ministers want to achieve and why, based in needs and linked to funding.
246	A strategy for the prevention of child sexual abuse, in all its forms, is developed and implemented by relevant Government departments.
247	Absolute priority is to invest in primary carers.
248	Action plans need to tackle causes not symptoms of problems in child care.
249	Agreed shared priorities across all aspects of the system (effective strategic planning driving improved service delivery).
250	An effective island diversity strategy is essential in addressing the challenges of an increasingly diverse community.
251	An effective, shared, management information system.
252	Budgets need to be greater for safeguarding related resources.
253	Celebrate success in Jersey and outwith.
254	Chief officers should drive and support a Children's Plan for Jersey.
255	Chief Social Worker role to be implemented with responsibility to drive up standards
256	Children and young people in care system to be the highest funding priority.
257	Children and young people to become the island's highest political priority.
258	Children's best interests to be central to all decision making.
259	Children's Minister essential.
260	Children's Minister needed.
261	Children's Minister.
262	Children's Services should be adequately staffed by trained personnel and be adequately resourced.
263	Clear leadership with vision.
264	Clearer shape and definition around future provision for children in care in Jersey.
265	Consideration of separation of dual functions of AG.
266	Co-ordinated, strategic approach to children and families that works across, and takes account of, the whole system that has children, and the rights of those children, at its heart.
267	Council of Ministers to have duty to respond publicly to annual report of IVYP.
268	Deliver the best possible care by putting the interests of children at the heart of all services.
269	Different States departments work together for the benefit of children and

	families, designing support around their needs.
270	Engaging HVR and other people coming to Island in helping build a community. Shetland model – transaction tax.
271	Establish the role of Chief Social Work Officer for the Island in legislation to ensure the role “has teeth”.
272	Establish the role of Chief Social Work Officer to ensure compliance with legislation, professional standards, advice on social matters to politicians and senior officers of the States.
273	Establishing what constitutes best practice internationally and then finding solutions which fit Jersey by establishing a consensus about what good outcomes for children would look like and then to search both the academic literature and services world-wide to find potential solutions.
274	Evidence base about children should Inform strategy; systems and processes must support strategy, being embedded through training and effective staff supervision.
275	Explicit public statement by the Government or chief officers about the aspiration for Jersey's children.
276	Explore how to strengthen the statutory responsibilities of organisations and professionals working with children, as part of their duty of care to children and young people, to ensure that all professionals work together more effectively to identify abuse.
277	Finance made available to improve support for families and enable children to reach their potential.
278	Focus in commissioning care to be as much about quality of inputs and outcomes as about costs.
279	Fostered children and young people should have the same aspirations as their peers and have the same opportunities including stable and lasting relationships, educational achievement and a positive experience of family life.
280	Full integration of health professionals into MASH and also to include full domestic abuse case assessment and vulnerable adult referrals.
281	Further inter-island co-operation to be explored.
282	Future shape of children's services in Jersey are designed to align with Jersey Social Policy; draw on best practice internationally; are adapted for Jersey; emphasise prevention but are adequately resourced to provide a measured response to improve outcomes for those children and families who find themselves in difficulty.
283	Good management information to help make decisions and good mechanisms to communicate it.
284	Government recognises the importance of and coordinates all sources of support for children and families where there is a particular risk of sexual abuse to ensure that victims are more effectively identified and helped.
285	Have the right services, policy and legislation in place to keep children safe, to help them reach their full potential and to ensure they have every opportunity to lead happy, rewarding and healthy lives.
286	High quality, evidence-based children's policy, incorporating a Children's Plan that is externally scrutinised and monitored.
287	Identification and delivery of shared priorities and actions across the whole system.
288	In line with article 39 of the United Nations Convention on the Rights of the Child, children in care and care leavers should be supported to recover from the effects of pre-care trauma.
289	In order to make significant progress Jersey needs to resource policy development to ensure that service delivery is informed by best practice and

	by ensuring benchmarking with relevant and appropriate jurisdictions and authorities.
290	Increasing voter engagement with political process.
291	Independent process for appointment of Solicitor General, AG, Dep Bailiff and Bailiff.
292	Initiatives to tackle child poverty.
293	Integrated approach to supporting care of children e.g. housing to look at needs of foster families, States provide assistance for families to extend their home to foster child, priority for housing given to foster carers; tax and social security systems to have provision to support foster carers e.g. contributions, pensions, allowances; HR to be more flexible in approach to remuneration and benefits for specialist foster carers.
294	Jersey must accept that protection of vulnerable costs, investment must happen especially in preventative services, must be sustained Investment, one off sums will only be helpful for a short time.
295	Jersey needs a party system that will allow people to come together around policies and principles rather than individual voices. “Something politically at a senior level has to require the system to deliver and hold it to account.”
296	Jersey politicians to set out a pledge to children in care.
297	Jersey should articulate its aspirations for children every year in a “mission” statement.
298	Jersey should have a Children's Minister.
299	Jersey should make explicit its aspirations for children, which are informed by a children's rights perspective and promotes inclusion, positive citizenship, welfare and protection.
300	Jersey should set itself apart from the other Channel Islands by aspiring to be a child focused and child driven island involving whole community playing a role in the improvement of the lives of children and young people.
301	Joint initiative between Educational Welfare Officer Team, care home representative, link educational psychologist and school to explore new procedures relating to how a collaborative and consistent approach could be established to improve the morning routine to increase school attendance of students who are in care.
302	Leadership – Visible support from States Members and chief/senior officers.
303	Minister for children and vulnerable adults.
304	Minister for Children.
305	Minister or someone to have power to deliver child care policy without it being stopped by Finance, HR or other committees/politicians who do not accept its importance.
306	Ensure more engagement with members of the public about their role in promoting the welfare and protection of children.
307	Increase funding for children's mental health services.
308	Change culture – Island needs to face up to problems and acknowledge mistakes.
309	Recruit HR people with specialist skill/knowledge of social services and demands/requirements of role and of specialist areas like foster carers.
310	Address problems of gaps in separation of powers and in role of Chief Executive.
311	Prioritise law-drafting time for children's legislation.
312	Put a needs analysis in place and utilised.
313	Keep Parish Hall Enquiry system as it is.
314	Participation structure for parents/carers to include consultation mechanism and minority groups, including parents of children with SEND – supporting service redesign, development and evaluation.

315	Use policy and legislation as imperatives to change and improvement.
316	Ensure political interest in and accountability for children's social work, its planning, review and outcomes.
317	Ensure that politicians and chief officers have opportunities to look at promoting improvement and driving transformation in other jurisdictions.
318	Ensure that politicians become more engaged with communities like The Bridge.
319	Promote 1001 Critical Days agenda.
320	Provide suitable housing for foster carers to enable families to care for children whose needs require specific environments to meet additional needs.
321	Use research to identify targeted opportunities for help i.e. self-harm, anxiety, bullying etc. which are then matched to what services already exist in Jersey and the capacity of those agencies.
322	Implement robust strategic planning for children with priorities for the Island, with shared aims and outcomes and an action plan owned across the whole system.
323	Have senior politicians and staff, including a Chief Social Worker, that both speak out for social work and hold it to account.
324	Separate Health and Social Services into two – because Social Services tends to get overlooked.
325	Provide significant further investment to develop children's services.
326	Develop social policy through voluntary sector and with engagement from whole community.
327	Change the fact that social work has historically been the “poor cousin” to acute health services.
328	Social work needs champions.
329	Involve social workers in wider strategies to bring about change not simply focus on individual families.
330	States of Jersey must avoid trying to make economies of scale by seeking larger institutional residential provision for people with complex care needs.
331	Ensure that States, as corporate parent, is held accountable for welfare of children in its care.
332	States members’ oath of office to be changed to acknowledge duties and responsibilities as corporate parent.
333	States should adopt the whole Inquiry report – not cherry-pick recommendations.
334	Implement a statutory duty for Jersey to develop a publish a plan for children's services similar to statutory duties in other jurisdictions Consider the need for outlining legal duties in relation to UNCRC and incorporate Corporate Parent role and duty.
335	Implement strategic planning ensuring that identified vulnerable children and young people receive the appropriate level of service and children with lesser needs are supported by universal and other support services.
336	Ensure strategic planning for developing the needs of children with disabilities as they move through system.
337	Strong political leadership to prioritise local investment in children and young people.
338	Ensure strong visible leadership at all levels (political, officer, community).
339	Provide sufficient resources to deal with high volume of domestic assaults.
340	Ensure sustained investment, higher aspirations for looked after children, quality standards.
341	Implement a system of “Champions” for looked after children.
342	Create a Strategic Group of Chief Officers, ideally chaired by the Chief Executive, to provide the necessary strong focus on children’s needs.

343	Reconsider, change and update the existing children and young people's framework document from 2011, to make it fit for purpose. Then it needs to be committed to and invested in.
344	Address the absence of policy development on a single agency and partnership basis in Jersey – in order to make sustainable improvement and progress across the whole children's services system to defeat silo working with the potential for duplication and no strategic approach or understanding to unmet need current or future.
345	Support strategic planning by secured, proactive funding and investment for social care provision, which is clearly communicated.
346	Clarify the aims and outcomes of the care system and how these will be measured going forward.
347	Give thought to the absence of protections balancing the substantial powers given to individual ministers. More controls and accountability needed in respect of politicians' influence.
348	Train States members on safeguarding and on corporate parent role.
349	Give welfare and protection of children a high political priority in Jersey.
350	Whole system approach.
	Safeguarding Children
351	Adopt the recommendations of Nuffield Report.
352	Ensure all agencies work together towards a common aim, the wellbeing and safety of children. In Jersey, departments are very 'precious' about their own and not willing to step outside that circle – this must change.
353	Ensure that all reports of injury and complaints by children, however minor, should be checked by Children's Services and medical records checked to see if there is a pattern of injuries.
354	Introduce better background checks on foster carers.
355	Ensure better local expertise in recognising child abuse.
356	Ensure that child protection is everyone's responsibility.
357	Child protection services must work together under one roof as a separate department for child protection and family support.
358	Give consideration to implementing a “Signs of Safety” practice framework.
359	Continue a multi-agency approach with all working together and valuing the strengths of each agency, exploring evidence based practice, researching what is needed on our island without duplicating work being done.
360	Continue investment to ensure SOJP officers are up-to-date in child protection and investigative knowledge and skills.
361	Don't focus on parents to the exclusion of the child's needs.
362	From the moment of initial disclosure of abuse, children should receive a holistic package of support, tailored to their needs, including therapeutic support to help them recover from their experiences.
363	Provide funding for SARC.
364	Provide further investment in public protection unit of SOJP.
365	Encourage General Practitioners to openly engage with the social care system.
366	Ensure that high quality information regarding what constitutes abuse, the processes regarding involvement with agencies, and details of any support networks are well publicised and communicated in the public domain as a preventative measure to increase public awareness.
367	Increase awareness of post separation abuse particularly in the family courts and with lawyers recommending mediation.
368	Increase investment in public protection unit to focus on early detection and prevention work.

369	Invest in a SARC.
370	Ensure more agencies are involved in the delivery of school sessions to teach specific topics such as PSHE or teachers could receive agency specific training to enable them to teach subjects most relevant to young people.
371	Increase understanding of the work of the agencies involved, how they operate and the value to the community of each one is very important.
372	Multi-disciplinary safeguarding training to be delivered by people with right experience and expertise.
373	Need to be proactive in anticipating and responding to CSE.
374	Need to co-ordinate victim services which is currently absent from SARC processes including victim therapy and family counselling support.
375	Police and children's services child protection teams to work together in same office.
376	Police to recognise impact of domestic violence and disputes on children and not leave them in the situation with nothing changed.
377	Ensure that there are practitioners across public, private and community and voluntary sectors who understand that safeguarding is everybody's business.
378	Introduce professional fostering, this prevents heading to an institution in the first place.
379	Professionals should look at children's patterns of behaviour and determine if they might be expressing consequences of maltreatment or abuse.
380	Look at reasons for children's behaviour and specialised help given. Should also recognise that children might have been victims of abuse.
381	Ensure safeguards against abuse in all facilities (States and privately run) to protect children. Children mustn't miss out on childhood.
382	Ensure that safety of child is paramount.
383	Ensure additional investment in SARC.
384	Ensure additional investment in SARC, following the review by Forensic Paediatrician Dr Louise Newbury in June 2015.
385	Ensure that schools have a coordinated approach in building good relationships.
386	Services to be easy to access for children and for members of public with concerns about children.
387	Shared ownership for the wellbeing and protection of children.
388	Introduce special measures for protecting and interviewing young people with special needs who are the most vulnerable.
389	Provide support for a primary care pilot to trial a pre-birth to 19 years safeguarding pathway to test if improved connectivity and communication with GPs will improve the services that children receive.
390	Provide support for development and integration of EMIS reporting system to link Family Nursing and Home Care health visiting records and GP records.
391	The Barnahus model of support for child victims of abuse should be piloted in Jersey having proved effective in other jurisdictions at improving victim experience and increasing successful prosecutions of abusers.
392	The needs of the parents/carers must never overshadow those of the children.
	Services for Children
393	Introduce a CAMHS specialist for looked after children.
394	Provide a clearly defined 14–16 pathway, focusing on developing essential life skills.
395	Introduce a more desirable model of CAMHS, which would involve the sharing of expertise with universal practitioners to improve the prevention of and escalation of Mental Health crisis in young people.

396	Consider a new role of embedded social worker in schools.
397	Ensure a properly structured fostering and adoption service, which would provide the appropriate support for young people with improved continuity.
398	Introduce a stand-alone dedicated YES shop within the town area (easy access for young people but still discreet to maintain confidentiality). This would be beneficial and increase the accessibility for young people to access support if they need it.
399	Ensure that a systemic response to cases is in place when social workers are off-duty or not at work.
400	Address the lack of tier 2 support services in the island.
401	Address the insufficiency of foster carers.
402	Address the lack of remand foster care and specialised therapeutic units, which results in children moving off Island or being placed in Greenfields.
403	Ensure that all schools equip all children, through compulsory lessons for life, to understand healthy and safe relationships and to talk to an appropriate adult if they are worried about abuse.
404	All schools take the necessary steps to implement a whole-school approach to child protection, where all school staff can identify the signs and symptoms of abuse, and are equipped with the knowledge and support to respond effectively to disclosures of abuse.
405	Ensure alternative provisions for children in care, development of using boarding schools.
406	Implement an agreed practice model in Jersey to work with children to reduce plethora of assessment formats, reviews, language and roles can be confusing to staff and makes engagement more difficult for children and families.
407	Introduce an agreed practice model or “team around the child” approach.
408	At present the offer of vocational study areas, for those most suited, has been accessed by small numbers of students from across the 11–16 schools.
409	Extend Barnardo’s participation scheme to cover children with disability receiving respite.
410	Ensure better support for families of children with disabilities, particularly during transitions.
411	CAMHS – develop tier 2 services to support parenting skills and emotional resilience in children and young people within the general population and those needing more specialist help in order to increase wellbeing and to reduce rates of serious mental illness and abuse.
412	CAMHS and Children’s Services should merge with education.
413	Introduce a charter for foster carers to agree they are respected and treated as skilled co-professionals, and recognised as part of the team working with the child, given the authority to make everyday decisions about the care of their fostered children, have better access to and consistency of social workers, receive proper financial support.
414	Introduce a commitment from the States of Jersey to using professional foster carers who can work regularly with the vulnerable families in Jersey.
415	Ensure commitment to having a team around the child and agreed multi-agency practice model with shared paperwork, language and procedures.
416	Give consideration to professional training, apprenticeships and the employment of Level 3 (fully paid) foster parents with a career structure for foster parents.
417	Give consideration to whether the social work service for young people could be redeployed around schools rather than communities as a means of improving stability and continuity of provision.
418	Ensure consistency of social or key workers who represent young people,

	who can ensure that no child is left behind and that the child remains at the centre of our focus.
419	Develop fostering resources.
420	Develop an intensive outreach CAMHS service to meet the needs of those young people who present with significant risk, needing daily support from a multidisciplinary CAMHS team working with staff from other agencies particularly residential care officers and intensive service support and with a close working relationship with a tier 4 adolescent unit to provide inpatient beds and advice.
421	Easier access to CAMHS.
422	Include child care professionals in Education Department management to reflect modern thinking and multi-disciplinary approaches.
423	Introduce a facility to prevent admission of 17-year-olds to adult psychiatric ward where they might be at risk.
424	Provide funding for full time counselling staff and further investment in the Youth Enquiry Service to increase the number of appointments and the type of support available to young people.
425	Provide further investment in the Youth Enquiry Service to increase the number of appointments available to young people.
426	Give greater support, resources and staffing for States schools – this is needed if we are to offer an alternative curriculum for highly challenging students not coping in a mainstream education setting, to re-engage children with their learning and ensure that all young people can go on to be economically active adults in our society.
427	Provide guidance and support for children who offend, including advice on their future.
428	Identify and remove barriers for young people to access health services, and improve co-ordination between professionals to ensure clear pathways of care.
429	Improve the provision, access and support of Mental Health services for looked after children/Young people, including out of hours services.
430	Make improvements to CAMHS.
431	Increase availability of counselling and therapeutic services for young people in Jersey to support their needs.
432	Ensure integrated support plans across Health, Social Care and Education, which are outcomes focused, with a team around the child and family ethos.
433	Intervene in families (e.g. counselling) to stop children coming into care.
434	Invest in programme for supporting high demand families.
435	Invest in treatment foster care for young people in youth justice system.
436	Ensure joined-up planning for respite care for young people with complex care needs.
437	Ensure a less frequent change of social workers – this also affects young people, their sense of security etc. as there is no continuity of an established relationship.
438	Provide literature for parents and children that is appropriately (not patronising) written regarding aspects of the care system I process.
439	Divert money spent on criminal justice system into mental health care for young people; a dedicated consultant psychiatrist and nurses.
440	Take more active responsibility and ensure collaboration by adult services where staff are working with parents.
441	Increase communication between agencies dealing with young people (education, police, charities etc.).
442	Increase flexible multi-agency services for vulnerable young people who are 17 and development of an adolescent or young adult service which would

	span the ages of possibly 16 to 24 – may be virtual but have the resources and flexibility to meet the needs of this population including those young people with an emerging borderline personality disorder.
443	Increase investment in Children's Services.
444	Ensure more life story work done earlier with children.
445	Increase respite services for children with disabilities.
446	Ensure online resources for families with child in care e.g. Ability to submit forms e.g. IRO.
447	Pilot social pedagogy approaches to improve outcomes for children and young people in foster care and or hub/constellation approaches.
448	Recruit professional foster parents.
449	Introduce professional fostering.
450	Make provision for vulnerable children/families to have a social worker when there is a change in social worker staffing arrangements.
451	Recognise that children are going to abuse substances – and experiment with new substances as they become available – and have right sort of help for them.
452	Introduce remand foster care and specialised care units to prevent use of secure accommodation/ children being moved off island.
453	Ensure alternative forms of care – Research shows residential care does not work for adolescents who have suffered abuse.
454	Provide resources to allow CAMHS to provide longer term therapeutic interventions to children who have been harmed by early life experiences.
455	Provide school-based family support workers, who would be a valued resource for schools to increase the capacity to work closely in a proactive manner with families and give them the sense of having a voice and being listened to.
456	Provide school-based social care workers with specific roles and remits, including Early Help case management.
457	Have a smaller statutory service, with a dedicated local workforce.
458	Introduce specialist foster care, including short breaks and longer-term care. This is required in order to ensure that children with additional needs have access to community based options.
459	Ensure that the profile of adoption and foster carers is raised further and their role is valued, celebrated and promoted.
460	Consider the Reclaiming Social Work model for Jersey in the medium term.
461	Redevelop the William Knott Centre in 2016/2017 as a Child Development Centre acting as a hub for services for children with complex needs.
462	Ensure a more seamless transition of services for child and family.
463	Develop Tier 2 Services to support young people, to enable CAMHS to focus on the significant number of young people who present with serious risk
464	Introduce training for foster carers and adoptive parents on the needs and emotional difficulties children have and how to respond. This should be ongoing – not a one-off training.
465	With the pending law change which is likely to sentence youngsters up to the age of 18 to Greenfields, give careful thought to how education will be delivered and the facilities available at that centre.
	Standards, Inspection and Scrutiny
466	Encourage a service where scrutiny is encouraged and where the voice of the child is welcomed and supported.
467	Put in place sound information systems to record and monitor activity and to provide timely management information.
468	Address the absence of an independent body such as the Audit Commission.

469	Develop aims and measures for care system outcomes in conjunction with young people.
470	All training should be subject to audit and evaluation in order to maintain high standards.
471	Further develop and communicate an effective system of multi-agency monitoring, evaluation and review.
472	Introduce an explicit, values based approach to work with children and families.
473	An inspection framework only gives minimum standards – ensure quality standards covering accountability, care planning and cohesive philosophy for residential care.
474	Introduce arm's-length audit and quality checking every year.
475	Ensure bespoke inspection on regular basis from OFSTED. Inspections need to be "invasive" and independent.
476	Introduce a Children and Young Person's Ombudsman modelled on Swedish ombudsman with role including promoting compliance with UNCRC and drawing also on model of Danish National Council for Children.
477	Establish a Children's Commissioner.
478	Develop care standards for children's services, in particular residential and adoption and fostering services. Increase advocacy services for children, perhaps using a model similar to children's rights officers or other organisations such as Who Cares? Review existing legislation to determine where strengthening is required to ensure the protection and promotion of welfare of the child.
479	Ensure external monitoring of children's services and facilities and providers of such facilities, including unannounced inspections.
480	External scrutiny and audit to be part of fabric of services.
481	Implement external scrutiny with the power to enforce findings and recommendations.
482	Increase external scrutiny and legislation that is routed in statute, giving inspectors rights of access to inspect. This should be across services – it is not sufficient that this is confined to regulating residential and domiciliary care and it needs to extend to education provision, housing, fostering and adoption and fieldwork services.
483	Establish an Independent Children's Ombudsman with status necessary to ensure recommendations are acted on by government.
484	Ensure an Independent external body to oversee management of child protection processes.
485	Ensure independent external oversight of internal review and professional audit
486	Ensure independent oversight and regulation of care from an external body with powers to hold organisations and managers to account.
487	Ensure independent scrutiny of police, public services, Law Officers'' Department (as happens with UK CPS) and courts. Line of reporting of independent inspections should be to an independent govt department, not just the inspected department.
488	Independent visitors – trained by JCLA – to visit children in residential care.
489	Ensure integrated Children's Services inspections that focus on outcomes rather than a focus on outputs and activity using a set of quality indicators to evaluate impact.
490	Jersey to have mechanisms that gives an external body scrutiny of SCRs.
491	Learn from reviews – each subsequent review in Jersey comments that the one previous hadn't been actioned or implemented.
492	OFSTED and Care Quality Commission to review progress over five-year

	period of response to Inquiry recommendations.
493	Introduce OFSTED and Police Inspections.
494	Ombudsman to be assisted by panel of experts and by panel of young people.
495	Ensure outside Inspection for the service.
496	Ensure outside scrutiny of departments involved with children including judiciary.
497	Introduce oversight from a body not connected or based on the Island on an on-going basis.
498	Introduce oversight from outside to ensure Jersey delivers appropriate legislation and policies.
499	Have a pattern of regular external review of social services.
500	Ensure proactive, hands-on monitoring.
501	Regularly review and inspect against outcomes and standards which are clearly understood.
502	Introduce regular reviews and visits to residential establishments by social workers.
503	SOJP to continue to submit to general and focussed voluntary inspections by UK agencies and with extensive links they have with UK forces.
504	Ensure somebody independent to scrutinise States of Jersey care.
505	Put in place standards such as Care Standards for residential care, or standards for services such as adoption and fostering or home care.
506	States of Jersey to have own internal care inspection regime.
507	Ensure strong quality assurance of services.
508	Consider whether the model of using young inspectors could be successful in Jersey to obtain the views of children about service provision.
509	Close the gap in legislation relating to the regulation, inspection and scrutiny of services.
510	Ensure that there is a commitment to consistent quality front-line practice, the communication of thresholds and their application.
511	There should be an agreed performance management and self-evaluation framework in place which is reviewed, analysed and acted upon, overseen, challenged and scrutinised by politicians.
	Transparency and Accountability
512	“Accountability is everything.”
513	A clear accountability framework for services to children and young people.
514	A culture of openness in which people can freely raise concerns.
515	A performance management approach.
516	Abolish “culture of protecting people that you have worked with for many years”.
517	Accountability – a children's ombudsman.
518	Acknowledge what happened to children in care in Jersey. Acknowledged it ruined lives.
519	Allow private prosecutions to be brought when AG will not prosecute.
520	Anyone taking on care of children should be clear about their legal responsibilities. There should be accountability and sanctions imposed when people fail in their duty of care.
521	Better representation for children and families in the court system.
522	Both SOJP should have clear media guidelines and an appointed spokesperson.
523	Children's Care Reviews need to be able to affect change for children Review officers need to be Independent, how can they be employed by HSSD and be independent? -They should function from Chief Minister's Office.

524	Civil servants to be more accountable for the way child protection is managed.
525	Clear boundaries between police and politicians and LOD.
526	Clear lines of responsibility to a Minister for children.
527	Clear transparent communication between all agencies and schools.
528	Clothier and Carswell reports to be fully implemented.
529	Cultural mould needs to be broken.
530	Effective systems for governance and accountability.
531	Every States department to carry out an audit and risk analysis in relation to child protection and child protection failings.
532	External reviews to be carried out by competent, independent people.
533	Greater accountability of Jersey's leadership.
534	Greater openness to share inspection findings and acknowledge problems.
535	Guidance for Council of Ministers on roles and responsibilities in relation to SOJP
536	Guidelines for politicians to follow in respect of relationship with SOJP.
537	If a UK style Independent Reviewing Officer model is continued then it should be properly independent and report in to Social Services at Director of Children's Service level or above rather than share the same service manager as the workers whose cases are reviewed.
538	Important for Jersey's leaders to own up to its past and to negative aspects of “the Jersey Way”.
539	Independent prosecution service.
540	IROs change too often and are often agency staff Reviews and reviewing officers should to be able to challenge agencies outside of HSSD effectively – not be simply a paperwork exercise.
541	Make sure anything like that would not happen again.
542	Meetings between SOJP officers and politicians should always be minuted by a civil servant.
543	Ministers to hold Chief Officers to account when things go wrong or departments underperform.
544	More mechanisms to challenge leadership of system.
545	More stringent checks on staff. Supervision and accountability.
546	More transparency and accountability in government. A more open and accountable political system.
547	Openness and transparency by all In the service – there has been a culture of defensiveness and avoidance.
548	Professional accountability for all professionals involved in working with children and young people.
549	Recruitment processes that focus on quality not “filling seats”.
550	Remove conflicts in Bailiff role.
551	SOJP should form a deeper and ongoing relationship with a neighbouring UK force
552	States to have an independent, elected speaker.
553	System that protects whistleblowers.
554	The Children and Vulnerable Adults Policy Group must be provided the authority to hold departments to account, and ensure good governance, in relation to the delivery of agreed strategic objectives.
555	The States to be “more open”.
556	There is a transparent, timely response to any queries from all agencies which recognises the value of the concern raised and gives reassuring, clear feedback.
557	Underperformance by States officers to be dealt with rather than quietly

	moving people away.
558	While lessons must be learned when things go wrong, there should also be a culture of holding people to account.
559	Whistleblowing process that is independent and removes fear of sanction for those who report concerns.
	Workforce Capacity and Development
560	Practitioners across public, private and community and voluntary sectors who understand that safeguarding is everybody's business.
561	“More control over child care officers” – who should be supervised and monitored
562	A clear strategy for the long-term staffing of social care is implemented, which adequately responds to the recruitment and retention challenges.
563	A commitment and investment in multiagency training of staff.
564	A comprehensive child protection training programme available covering different levels of training need. The programme needs to be adaptable to changing trends both locally and nationally.
565	A focus on managers and leaders, upskilling to ensure effective use of resources.
566	A huge investment in recruiting the highest quality of teachers for schools so that children are given the best opportunities for success.
567	A training needs analysis and subsequent training programme implemented which is supported with appropriate updates – training shouldn't be a one off, Review all reported Incidents, consider themes that can be addressed.
568	Access to appropriate CPD for staff on a single and multi-agency basis using a tiered approach appropriate.
569	Address recruitment, employ right staff – emotionally Intelligent, from top to bottom, invest, value and motivate them, they'll stay, Constant interims are disruptive for everyone, creating risk In Itself.
570	All staff to have access to and be expected to attend courses in line with professional development.
571	All management posts at Grade 12 and above should have their job descriptions and person specification reviewed. An outside agency should be involved either a Local Authority or NSPCC Consultancy. A representative should sit on the interview panel to ensure the applicants C.V. meets the criteria for the role.
572	All staff should receive regular CPD and supervision focused on improving client outcomes and developing worker skills.
573	All staff to have a personal record of the training attended in each year and a plan for ongoing professional development. Specialist courses such as supervision skills and training/or trainers to be provided at a subsidised cost. Staff released to attend these longer courses.
574	All teachers in all schools are trained and supported to understand the signs and symptoms of child sexual abuse as part of initial teacher training and ongoing professional development, with the latter requirement reflected in statutory guidance.
575	An adequate level of staffing within H&SS ensures caseloads are manageable and realistic, with actions implemented and outcomes communicated.
576	An ethos in children's services where staff aspire to do their best for looked after children and are fully supported in this goal throughout the hierarchy of staff.
577	An on island training programme to develop social work staff.
578	Basic awareness training child protection/safeguarding should be mandatory.

579	Be open and encouraging and look to the external environment for best practice and learning.
580	Better connection between senior staff and RCCOs.
581	Better training so staff speak out about abuse. Training on bullying, on whistleblowing.
582	Care staff to have an open discussion forum with managers and access to a confidential facility where they can express concerns without fear of retribution.
583	Changes to key staff and key policies at Social Services are communicated to all agencies.
584	Child care officers, and home staff, to be properly vetted.
585	Children who are least articulate and therefore potentially most vulnerable are those with complex emotional and/or learning disabilities should not be looked after by untrained staff who can increase the challenging behaviour by mismanagement.
586	Competent staff trained in line with best practice.
587	Consistent and substantively employed staff and less reliance on bank staff affects how children develop supportive, therapeutic relationships.
588	Consistent social workers.
589	Development of a Higher Award Jersey Safeguarding Training Course accredited by a UK University Specialist courses could be taught by experts brought to the island at particular times.
590	Ensure adequate training for foster carers to meet the needs of children with complex needs.
591	Ensure foster carers are valued as equal member of the team around the child.
592	Find ways to motivate the good people in the system who have become “fossilised”.
593	Foster carers must be skilled and knowledgeable, therefore initial and ongoing training and development is essential.
594	Further training for health visitors on assessing attachment and promoting attachment in evidence based format to be funded.
595	Involve young people in recruitment of Residential Staff.
596	Improve communication between care staff and Children's Services.
597	Increase capacity in staff across a range of roles and levels.
598	Recruit staff from outside of the island, and it is important that they receive a thorough induction into local structures, legislation policy, practice and culture.
599	Invest in high quality training and support for foster carers.
600	Invest in staff development.
601	Prioritise the recruitment and retention of the highest quality professionals working across all aspects of Health and Education services for young people.
602	It would be helpful to schools to have a clear understanding and outline of the key roles and responsibilities of the key workers of the students in care and how operations work with shift changeovers.
603	Jersey must compete in terms of salary and other terms and conditions to attract the best staff.
604	Jersey needs to embed a learning culture: how it goes about its business, whether in relation to self-evaluation, scrutiny and inspection or service planning and development.
605	Leaders and Managers should be developed locally wherever possible, with training recognising the importance of understanding the evidence base for providing children's services as well as managerial skills.
606	Managers need to be aware of the function, purpose and benefits of inter-

	agency training.
607	Implement a policy that senior managers must have a professional qualification. Members of the public have the right to expect that professionals hold the appropriate qualifications and are registered with a professional and regulatory body.
608	Members of the Safeguarding Board should ensure that their staff attend inter- agency training.
609	Recruit more staff with training in working effectively with children with complex disabilities and ensuring their rights are advocated and respected.
610	Provide multi-agency supervision, particularly around building professional relationships where challenge is respected, to counteract poor sharing of information and silo working.
611	Provide multi-agency training, and a framework for what a better working relationship with GPs might look like.
612	Ensure “circulation” – staff on Jersey to spend time off island, learning in other settings and opportunities for people from elsewhere to be seconded in to Jersey. Setting up an improvement partnership with a UK authority and focussing particularly on developing team managers.
613	Negativity – it makes us feel like shit (e.g. staff saying “I will be glad to finish my shift, leave this place and go home” – don’t say that – it is our home).
614	Develop a partnership relationship with a Local Authority in the UK, in which a Jersey social worker could spend a year working in front line child protection If the area has a University, then a post qualifying qualification could also be gained. A UK social worker would at the same time spend a year working in Jersey, this would help to introduce a fresh perspective and new ideas.
615	Ensure professional and personal boundaries are distinct allowing mature professional challenge and difference to 'get the job done' and 'do the right thing.
616	Strengthen professional links and learning with the external environment.
617	Identify and support professionals with potential in gaining qualifications in the UK.
618	Ensure promotion in care system by merit not by being part of “old boys’ system”.
619	Ensure proper multi-agency work, which will take time and Involves those professionals training together.
620	Provide more training and a deeper understanding for all people working in areas that concern young people and mental health.
621	Establish a Residential Child Care Officer independent forum to allow free exchange of views and issues without fear of reprisals.
622	Engage Residential Child Care Officers more in decision-making.
623	Ensure that recruitment is rigorous and includes assessment of competence, behaviours and characteristics and values.
624	Subject residential children's services staff to regulation and a minimum qualification requirement.
625	Draft service standards and policies which are clear and easily accessible, and provide a clear framework for practitioners to work within using their professional discretion.
626	Shared training for staff at all levels using a tiered approach e.g. awareness raising, skills.
627	Provide single agency training and multi-agency training, which serve both different and similar objectives. They should work sympathetically and parallel to each other.
628	Ensure that social workers and family support workers within the complex needs team have a thorough understanding of disability and have the skills to

	effectively communicate with, and safeguard, the most vulnerable young people.
629	Staff at all levels must be more professionally mature and accept necessity of professional challenge.
630	Staff must be consistent and follow through with what is agreed e.g. if a phone call is promised on a particular day, do it at the right time not a week later or never.
631	Staff to get training regarding medicines management, self-harming, training regarding mental health.
632	Staff to keep and be encouraged to keep live links with other jurisdictions and professional organization.
633	Strengthen workforce planning including succession planning, skill mix, qualification required for the job regulation of staff.
634	Ensure that there is a strong professional leadership, which is visible and valued.
635	Ensure that there are suitably qualified staff heading up the service.
636	Provide support for staff that feel that things are not right within the system and an alternative platform for them to voice their concerns without fear of losing their jobs.
637	Improve the collection of data and use it to inform training needs.
638	The Education Department should implement a whole-school approach to child protection, where all school staff can identify the signs and symptoms of abuse and are equipped with the knowledge and support to respond effectively to disclosures of abuse.
639	The individual who is leading Children's Services should be an experienced specialist embedded in the culture and practice of this professional discipline.
640	The Jersey Government needs to ensure there is adequate investment in training and support for foster carers.
641	Improve the way professionals talk to parents' needs. Professionals need to understand how scared parents feel and that they are trying their best and to respond when they ask for help.
642	There is a clear outline of the staff training and qualifications for those staff who work in care homes in order to support the consistency of approach when dealing with youngsters.
643	Ensure that there is a clear, published definition of the capacity, roles and responsibilities of schools, namely senior school leaders, in relation to the social care system.
644	Ensure that there is a clear, published definition of the capacity, roles and responsibilities of schools, namely senior school leaders, in relation to the social care system.
645	Establish training and development plans for local workers. The whole island must take responsibility for children.
646	Ensure training and induction [for staff] – this would help.
647	Ensure training and support and access to expertise for Residential Staff.
648	Ensure training for all staff in schools to improve the awareness, recognition and skills of teachers faced with the challenges of vulnerable children.
649	Training for RCCOs to be undertaken in work time.
650	Training needed for RCCOs on legal highs/self-harming/suicide/pressures of social media, counselling/behavioural therapy and anger management and training for career progression to maintain morale and motivation.
651	Training Officers to work at strategic level to be involved in practice development and change programme.
652	Training to be given on risk management – being able to recognise what should be escalated up and where to escalate matters to.

653	Training to have a pan-island perspective with the formation of a panel of training officers from all agencies to coordinate training avoid duplication and share knowledge and skills.
654	Give adequate resources to training.
655	Ensure UK training for social workers.
656	Recognise the value of appropriately qualified, knowledgeable and skilled staff whether residents or not.
657	Ensure vetting of staff and proper training.
658	Workers need to be clear about what is expected of them; to have reasonable workloads; to be supported when they make defensible decisions which turn out badly; to have supervision and support which recognises the stresses of the role.
659	Establish a workforce development strategy that complements local priorities.

The recommendations that we do not support, or do not support in their current form, are as follows:

- **182:** *ABE interviews to involve an intermediary or suitably qualified child psychologist.*

While we are supportive of children having access to an advocacy worker to support them in such interviews, we consider it important to avoid pathologising children.

- **193:** *Consider re-opening the Maguire case.*

We recognise that there are a number of victims who understandably feel they have not received justice in respect of the abuse which they allegedly suffered at the hands of the Maguires. We therefore consider that there is merit in considering whether there is scope for re-opening the case in the event of new evidence becoming available. We are of the view that this needs to take into account the likelihood of a successful prosecution, to avoid further disappointment for the victims.

- **195**. *Change the mindset of the judiciary – they are not child care experts and so should listen to those who are.*

We are concerned that this could be taken to imply that judges should accept expert evidence at face value and without question. That is not the role of judges, who are required to weigh up all evidence presented to them. It would,

however, be important, in our view, that judges receive regular training to support their decision making in matters relating to children.

- **237, 259, 260, 261:** *A Children's Minister.*

We are not persuaded that this, in itself, would resolve the many issues that require to be addressed. We are of the view that our recommendations will put in place the necessary changes and structures to ensure the wellbeing of the island's most vulnerable children. What is essential is that those Ministers whose responsibilities include policies and services pertaining to children make a full commitment to their corporate parenting responsibilities.

- **273**: *Appointment of a Chief Social Work Officer.*

This appears to be based on the Scottish model that has been in place since 1995. This replaced the previous requirement for local authorities to appoint a Director of Social Work, which had been enshrined in the Social Work (Scotland) Act 1968. We urge caution about simply replicating a model from elsewhere. We are mindful of the advice that we received when we visited the London Borough of Hackney. Their strongly held view was that other places could not simply uplift the "Hackney model" and transplant it into their service. Their advice was that authorities had to develop their own model that fitted with their own needs and culture, in the same way as Hackney had arrived at their very successful model of service delivery**. We are also not convinced that Scotland offers the best model of children's services to be followed in Jersey, where the law is more closely aligned to the law of England.**

- **314:** *Parish Hall Enquiry system to remain.*

We do not agree, and are of the view that there is a need to consider whether the long-established system is fit for purpose in the 21st century. **We are not convinced** that it has sufficient checks and balances to ensure that the needs of young people are met, or that Centeniers have sufficient knowledge and training in respect of youth justice to be the arbiters of how the needs of young people should be met.

- **440:** *Diverting resource from the justice system to invest in mental health services for young people.*

While we are supportive of the need for good mental health services for young people who require them, we caution against pathologising young people: offending behaviour is not indicative of a mental health problem in the majority of cases, and, where a young person does have a mental health problem, it may have no relationship to offending behaviour. We do strongly recommend that a welfare-based whole-system approach to young people should lie at the core of future services.

APPENDIX 4

List of Contributors to Phase 3

Phase 3a

The Panel met with or visited the following individuals and agencies to learn about and learn from their work. In some locations it met with staff groups, in others with a manager, and with members and service users in others. Some individuals have asked not to be identified.

- 1001 Days Initiative
- Action for Children, UK
- Adoption UK
- Audit Jersey
- Barnardo's
- Brighter Futures
- Dr Zoe Cameron
- CAMHS (Child and Adolescent Mental Health Service)
- CELCIS (Centre for Excellence for Looked After Children in Scotland)
- Chief Executive of Health and Social Services Department, Jersey
- Chief Social Worker for Children and Families, England
- Child, Youth and Community Tribunal, Guernsey
- Children's Commissioner, England
- Children's Commissioner for Wales
- Children's Hearings, Scotland
- CIRT (Children's Initial Response Team)

- Current and former interim Senior Managers, Health and Social Services Department, Jersey
- CYCJ (Centre for Youth and Criminal Justice), Scotland
- Department for Education, England
- Director of Children's Health and Social Care, Guernsey
- Former Children’s Commissioner, Scotland
- Former Director of Who Cares? Scotland
- Foster Carers
- Friends of the Bridge
- GP, Jersey
- Health Visitor for Looked After Children
- Health Visitor Team Members and Team Leader
- HMP La Moye
- Honorary Police, Jersey
- Housing Jersey
- Howard League for Penal Reform
- IVYP (Independent Visitors for Young People)
- Professor Alexis Jay (formerly SWIA – Social Work Inspection Agency)
- Jersey Child Care Trust
- Jersey Primary Care Body
- Jersey Youth Service
- Lord Laming
- Les Amis, Jersey

- Lieutenant Governor of Jersey
- London Borough of Hackney
- MASH (Multi-Agency Safeguarding Hub)
- MECSH Champion (Maternal Early Childhood Sustained Home-visiting)
- Professor Eileen Munro, London School of Economics
- National Fostering Agency
- Nationwide Association of Fostering Providers
- NSPCC, Jersey
- Ofsted, UK
- Orchard House, Jersey
- Parent Voice, Jersey
- Parents using Children's Services
- Probation Service
- Scottish Children’s Reporter Administration (SCRA) (Children’s Hearings)
- Mary Varley – formerly Ofsted, UK
- Staff of Robin Ward and Community Paediatrician
- The Fostering Network
- Welsh Government advisers, health and social services
- Who Cares? Trust, London (now re-named “Become”)
- YES Project
- Young people currently in the care system
- Youth Court.

The Panel also undertook a number of site visits to current and former child care establishments.

Phase 3b

The Panel received expert evidence (for example, from Professor Bullock) in the first phase of the Inquiry, and drew on that evidence and accompanying reports (see Appendix 6: The Bullock Report and Parker Report) in developing recommendations.

Phase 3c

Members of the public and community organisations were invited to share their views and ideas on the future of child care services in Jersey. Contributions were received from:

- Anonymous: 10 members of the public who did not want their names to be published
- Anonymous: one person who provided no personal details
- Mr Robert Andrews
- Brighter Futures
- Ms Janet Brotherton
- Mr Norman Cooke
- Jersey Voluntary and Community Sector Ltd
- Jersey Women’s Refuge
- Belinda Lewis
- Safeguarding Partnership Board
- Dr Clifford Spratt
- Voice for Children.

Phase 3d

The following individuals and organisations contributed to the Panel's "Stakeholder Consultation", which invited people and agencies most concerned with the delivery and receipt of services for children and families to provide their views on the future of Jersey's child care system. Some contributors had also participated in Phase 3a.

- Action for Children
- Brighter Futures
- Brook Charity
- Dr Zoe Cameron
- CAMHS
- Alan Collins
- Early Help Co-ordinator
- Education Department
- Family Nursing and Home Care
- Senator Ian Gorst, Chief Minister
- Senator Andrew Green
- HSSD
- IVYP
- JCLA (Jersey Care Leavers' Association)
- Jersey Women's Refuge
- Jersey Youth Service – YES Enquiry Service
- NSPCC
- Probation Service

- John Richardson, Chief Executive to the Council of Ministers
- SOJP (States of Jersey Police)
- The Fostering Network
- The Who Cares? Trust (now re-named “Become”).

The following people participated in round-table discussions with the Panel, on the future of children’s services in Jersey. Some attended individually, others participated with colleagues and some joined in multi-agency discussions. Some had participated in the Phase 3c consultation and were invited to expand on their submissions to that process. The Panel also met some of these contributors in Phase 3a meetings.

- Anita Arnott, Health Visitor
- DCO Robert Bastable, SOJP
- Louise Clark, IVYP
- James Clarke, Interim Manager, HSSD
- Alan Collins, Solicitor
- Nick Cook, Barnardo’s
- Juliette De Guelle, Jersey Foster Carers Association
- Susan Devlin, Managing Director, Community and Social Services.
- Justin Donovan, Director of Education
- Shaun Findlay, Les Amis
- Julie Garbutt, CEO, HSSD
- Julie Garrod, Adoption Panel
- Senator Ian Gorst, Chief Minister
- Senator Andrew Green

- Supt Stewart Gull, SOJP
- Brian Heath, Probation Service
- Debbie Key, Health Visitor
- Jeanette Lambert, Health Visitor
- Ann Le Rendu, Jersey Foster Carers Association
- Jane Long, Health Visitor for Looked After Children
- Jill Gracia, JCLA
- Jim Hopley, Jersey Voluntary and Community Sector Ltd
- Lisa Le Maistre, IVJP
- Kate Maher, Action for Children
- Neil McMurray, Voice for Children
- John Pinel, Jersey Voluntary and Community Sector Ltd
- Marie Raleigh, MECSH Champion
- John Richardson, Chief Executive to the Council of Ministers
- Senator Paul Routier
- Emma Smale, Action for Children
- June Summers Shaw, Fostering Panel
- Patricia Tumelty, The Bridge
- Kevin Williams, The Fostering Network
- Julie Wise-St Leger, Interim Manager, HSSD.

The transcripts of Phase 3d hearings, and those submissions to Phase 3c and Phase 3d that contributors were content to be made public, are available online at www.jerseycareinquiry.org. There is a wealth of compassionate, creative thinking in

this material, which should be read and used to inform future child care developments in Jersey.

APPENDIX 5

Glossary

ABE	Achieving Best Evidence
ACPO	Association of Chief Police Officers
AfC	Action for Children
AG	Attorney General
BINOCC	British and Irish Network of Child Commissioners
BYD	Brig-y-Don
CAMAT	Child Abuse Multi-Agency Training
CAMHS	Child and Adolescent Mental Health Service
CCA	Child Care Assistant
CCO	Child Care Officer
CELCIS	Centre for Excellence for Looked After Children in Scotland
CEO	Chief Executive Officer
CIRT	Children's Initial Response Team
CO	Children's Officer
CPO	Chief Probation Officer
CPS	Crown Prosecution Service
CPT	Child Protection Team
CQSW	Certificate of Qualification in Social Work
CS-C	Children's Sub-Committee
CYCJ	Centre for Youth and Criminal Justice
DC	Detective Constable
DCI	Detective Chief Inspector
DCO	Deputy Chief Officer
DfE	Department for Education (England)
DI	Detective Inspector
DS	Detective Sergeant
DSupt	Detective Superintendent
ECHR	European Convention on Human Rights
ECSD	Education and Children's Services Department
FGH	Family Group Home
FPT	Family Protection Team
GSSC	General Social Care Council
HDLG	Haut de la Garenne
HCPC	Health and Care Professions Council
HDLG	Haut de la Garenne
HR	Human Resources
HSS	Health and Social Services

HSSD	Health and Social Services Department
HVR	High-Value Resident
HYPP	Homeless Young Persons Project
IRO	Independent Reviewing Officer (working within ISS)
ISS	Independent Standards and Safeguarding Team
IVYP	Independent Visitors for Young People
JCLA	Jersey Care Leavers' Association
JCPC	Jersey Child Protection Committee
JHFB	Jersey Home for Boys
JHFG	Jersey Home for Girls
JSPB	Jersey Safeguarding Partnership Board
LAC	Looked After Children
LOD	Law Officers' Department
MAS	Merit Award Scheme
MASH	Multi-Agency Safeguarding Hub
MECSH	Maternal Early Childhood Sustained Home-visiting
MOfH	Medical Officer for Health
MOH	Medical Officer of Health
MPS	Metropolitan Police Service
NNEB	National Nursery Examination Board
NSPCC	National Society for the Prevention of Cruelty to Children
OIC	Officer in Charge
PHE	Parish Hall Enquiry
PIC	Public Instruction Committee
PLO	Public Law Outline
PPU	Public Protection Unit
PRC	Parenting Research Centre
PSHE	Personal, Social, Health and Economic Education
RAG	Red, Amber and Green
RAID	Reinforce, Appropriate, Implode, Disruptive Training
RAMAS	Risk Assessment Management System
RCCO	Residential Child Care Officer
SARC	Sexual Assault Referral Centre
SCCO	Senior Child Care Officer
SCR	Serious Case Review
SCRA	Scottish Children's Reporter Administration
SCSWIS	Social Care and Social Work Improvement Scotland
SEND	Special Educational Needs and Disability
SG	Solicitor General
SIO	Senior Investigating Officer
SOJP	States of Jersey Police
SMART	Specific, Measurable, Assignable, Realistic and Time-related

SWIA	Social Work Inspection Agency (later SCSWIS, now Care Inspectorate)
TCI	Therapeutic Crisis Intervention
UNCRC	United Nations Convention on the Rights of the Child
YAT	Youth Action Team
YP	Young Person

APPENDIX 6

The Bullock and Parker Report

A REVIEW OF SERVICES FOR CHILDREN IN CARE IN THE UK SINCE 1945 AND A COMPARISON WITH THE SITUATION IN JERSEY

A paper prepared for the Jersey Independent Care Inquiry

Roger Bullock
Roy Parker

July 2014

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A REVIEW OF SERVICES FOR CHILDREN IN CARE IN THE UK SINCE 1945 AND A COMPARISON WITH THE SITUATION IN JERSEY

AIMS AND STRUCTURE OF THE PAPER

The purpose of this paper is to chart historical developments in children's services in the UK since the end of World War II and to compare what has happened in Jersey with the situation elsewhere, especially England.

It is a maxim of historians that we can only understand the present state of affairs by analysing our history. But there are several ways of doing this: one is to discuss changes using a time-line composed of important milestones and a second is to draw out general trends, in this case with regard to social work policy and practice with children in need. Both methods will be used in this paper.

Once the history (Part 1) has been charted, the policy/practice trends (Part 2) will be identified. For each historical period, a comparison will be drawn between legislation and guidance in the UK and in Jersey.

PART 1
Milestones in the Development of Children's Services in the UK since 1945

Introduction

1. The interaction between the factors influencing childcare policy and practice, such as conviction, war, the media, research, legislation and professional development, is complex[i]. A force for change in one situation, such as radical legislation that imposes a new activity on professionals, can hold things back in other circumstances, such as when legislation lags behind public opinion. Thus, the factors affecting change are radical and reactionary at different times, a situation that has to be borne in mind in any history of social policy.

2. Two other notes of caution have to be sounded before commencing. The United Kingdom comprises four countries and there are differences in legislation, administrative arrangements and professional structures. Obviously a four-fold review of every point would be cumbersome and unnecessary as the general aims of services are similar. Nevertheless, there are some important differences in the history of services. Scotland, for instance, operated a poor law system that was different from that elsewhere, had a different education system and a high rate of fostering (around 75% in 1948) for children in care. Also, the Scottish Office as a single government department was able to introduce change more easily than was possible in England, so setting a continuing tradition of reforms coming from central government rather than from practitioners or researchers. Differences in the administration and details of services continue, the most significant of which is the use of child hearings rather than courts to make decisions and the ability of the local panel, whose members comprise a mixture of lay and professional

people, to specify where a child should live, irrespective of the recommendations of professionals. There is rarely disagreement but this did create a problem in Fife in the 1990s when the director of children's services refused to implement the panel's decision to send a boy to a boarding school that he thought was abusive. This led to a judicial inquiry that upheld the panel's legal right. In addition to this difference, the age of criminal responsibility is set at eight rather than 10 as in England and Wales, gay and lesbian couples were barred from fostering until 2009 and there is a sympathetic view of residential care whose work is supported by a government-funded research institute[ii].

3. In Northern Ireland the implementation of the *Children's Order* of 1995 made the child care system very similar to that of post-1989 *Children Act* England and Wales. However, the administration has long been marked by a much closer relationship between children's services and the local Health Board(s) – there is currently a single Health Board making the whole country like one large UK local authority.

4. Secondly, few statistics seem to be available on children receiving services in Jersey and there are no authorities in the UK that offer a comparison in terms of size and socioeconomic characteristics. The nearest equivalent would be a district council but information is not published at this level. There are some small authorities in Wales and Scotland but none appear to have social and economic contexts similar to Jersey. All of this makes interpretation and comparison difficult but some forecast can be made.

5. With regard to children in need, the annual government survey shows that in England on March 31st 2013 378,000 children were receiving a service and 52,000 were subject to a care plan. Rates varied from 785 per 10,000 children in poor areas to 154 in the more prosperous ones. Just over a quarter (26%) of the children were aged under five and 30% were aged 10-15. During the financial year 2012-13, there were 593,000 referrals, 441,500 of whom received an initial assessment and 232,700 of whom were the subject of a child protection investigation (Section 47).

6. With regard to looked-after children, in England, there were 68,000 children in care on March 31st 2013, a rate of 6.0 per 1,000 under 18s living in the area (this rate tends to be higher in deprived areas, although the association between these rates and measured need is not particularly strong). Of these, 55% were male, 78% were white British, 6% were aged under 1, 19% 1-4, 19% 5-9, 36% 10-15 and 20% sixteen or over. The reasons for care were: abuse and/or neglect 62%, child's disability 3%, parental illness 4%, family under acute stress 9%, family dysfunctional 14%, unacceptable behaviour 2% and absent parent 5%. Legally, 59% were on care orders (42% full, 17% interim) and 29% were in care under voluntary arrangements. The rest were freed for adoption or subject to a placement order.

7. Each year in England, around 28,000 children enter and leave care. Of those coming into care in 2012/3, just over half (53%) were male and 73% white British. Their ages were: 21% under one, 20% 1-4, 17% 5-9, 30% 10-15, and

12% sixteen or over. Reasons for admission were abuse and/or neglect 56%, child's disability 3%, parental illness 4%, family under acute stress 10%, family dysfunction 18%, unacceptable behaviour 3% and absent parent 7%.

8. These surveys suggest that the number of children receiving a service at any one time is about five or six times the number of those in care. So, applying these rates to Jersey, it would be expected that about 600 children in need would be receiving a service at any one time and that about 90 of them would be looked after. In the course of a year, the figures would be about 950 for children in need with about 40 coming into and leaving care.

9. Having identified the difficulties of the exercise and set the context for the discussion, the time-line of legislation will be charted.

The situation prior to 1948

10. Until 1919 the poor law responsibilities for children were vested in the Local Government Board centrally and the numerous poor law guardians locally. With the creation of the Ministry of Health that year, responsibilities were passed to the new department and the LGB disappeared.

11. Throughout the latter part of the 19th century the Home Office was responsible for the registration and inspection of the industrial schools and reformatories most of which had been set up after the 1850s by philanthropic bodies, almost all religious. After 1889 (*Prevention of Cruelty to Children Act*), it was responsible for the Fit Person Order system. As the term implies, a fit person was anyone considered suitable by the court to assume responsibility for a child judged to be in need of care and protection. However, from the start few private individuals were nominated and children were mostly committed to the care of corporate bodies, initially mostly the voluntary children's societies, such as Barnardo's, but increasingly the Poor Law authorities. However, the 1889 Act specified that the fit person had to be a named individual and this requirement sat uncomfortably with commitment to an organisation. Dr. Barnardo himself especially disliked the idea of being held individually responsible rather than the organisation. Hence, five years later the legislation was amended such that a corporate body could be regarded as a 'fit person'. Later, there was a Home Office Children's Branch that appointed inspectors and kept the statistics.

12. The Children Act 1908 was another important milestone but is only relevant to this history in that it widened the disposals available to magistrates to deal with young offenders. It provided alternatives to placement in industrial schools or prison custody, options that were further extended by the *Probation of Offenders Act* that soon followed and instigated community supervision. It is important to note, however, that these changes were not all progressive - another possibility was whipping.

13. The next important change came in 1930 (*The Local Government Act 1929*) with the replacement of the hundreds of local boards of poor law guardians by local authority public assistance committees. These administered the poor law

that included provision for the care of separated children. This change involved a major administrative reorganisation, for example the London County Council took over responsibilities from 25 groups of Poor Law guardians. Centrally, the Ministry of Health remained responsible for this as well as for the oversight of private fostering and private nurseries under the child life protection legislation, functions that fell to the medical officers of health and their staff locally.

14. Thereafter came the 1933 *Children and Young Persons Act*. It specified (Section 96(1)) that when children were committed to the care of the local authority on a fit person order, the county councils and county boroughs had to discharge their responsibilities through their Education Committees and not their Public Assistance Committees that administered the Poor Law. This reflected certain long-standing tensions between the Home Office (with overall responsibility for committed children) and the Ministry of health that oversaw the administration of the Poor Law. Furthermore, the Home Office had responsibility for the juvenile courts. One of the points of tension between the two central government departments was the respective roles of institutional and foster care. The Ministry of Health was markedly uneasy about the encouragement of foster care, believing that it provided insufficient protection for children against exploitation and misuse. The Home Office on the other hand, was much more enthusiastic about foster care and saw to it that the regulations associated with the 1933 Act required children subject to fit person orders to be boarded-out unless there were good reasons why that should not happen.

15. Other changes concerned the constitution and powers of the juvenile courts. The industrial schools were renamed approved schools (approved by the Home Office) and certain changes were introduced concerning the ages and duration of committals to these institutions, such as imposing a three-year maximum on how long children could be kept in an approved school.

16. So, by 1939 the government departments responsible for 'child care' were the Home Office and the Ministry of Health – but not Education. Locally, however, there were the public health committees, the public assistance committees and the education committees – all responsible to the parent local authority and its elected members.

17. In the context of the post-war enthusiasm for social reform, and especially the dismantling of the poor law, this untidy legal and administrative arrangement soon became the subject of outside scrutiny and the services that we see for children in care, or looked-after children as they are now called, today reflect the far reaching legislation of 1948.

1948-63

The Children Act 1948

18. A major review of services for children was underway in the last years of the Second World War and the outcomes of this, the 1946 Curtis Report in England and the Clyde report in Scotland[iii], provided the framework for the

new legislation. The need for reform was also highlighted by the death of a foster child (Dennis O'Neill) from physical abuse and malnutrition in January 1945. The Monkton Inquiry[iv] into the circumstances surrounding Dennis's death revealed poor placement selection and supervision and raised general questions about the wisdom of placing children a long way from home (90 miles in Dennis's case), the lack of expert staff (the home area education department had few people knowledgeable about foster care) and the selection of foster parents (Dennis was on a fit person order, placed on a small farm and was expected to muck out).

19. The 1948 Act brought together three strands of provision for children who could not live with their families because their close relatives were unable or unwilling to look after them. This provision was being administered locally by public assistance committees (poor law), education and health. The Act ordered the setting up of a Children's Committee and the appointment of a Children's Officer in every local authority. In most cases, a separate Children's Department was created, but this was not a legal requirement and in some authorities the service remained in the clerks' department while in some smaller ones facilities were shared, as between Cornwall and the Isles of Scilly.

20. An especially important aspect of this change was that it moved responsibilities for child care out of the other local departments into a separate specialist one. With the abolition of the poor law, child care was no longer associated with stigma and issues associated with cash benefits and matters to do with care became separated. It did not, however, repeal the 1933 Act which continued to operate in parallel until 1969 with children committed by a fit person order under the 1933 Act placed in Children's Departments.

21. The 1948 Act maintained the distinction first introduced in 1889 by the *Poor Law Amendment Act* that allowed the local poor law authorities to pass a resolution to assume parental rights over children already in care. There had to be a good reason – usually that the child would be endangered if returned home – but the guardians did not have to seek the court's permission. It was an administrative procedure. Parents could seek to have the resolution withdrawn, but they had to bring their case to court and then the court decided whether or not the order should stand.

22. This provision meant that the guardians, later the pubic assistance committees, then the children's departments and finally the social services departments could keep a child in care against the wishes of the parent(s). This procedure was not abolished until the 1989 *Children Act*.

23. This parental rights resolution could only be applied to children who were in care on a 'voluntary' basis. Those on fit person orders could be kept in care against parental wishes in any case, although there were provisions for applications for the discharge of the orders.

24. Interestingly, despite bids from the Ministries of Health and Education, the Home Office was nominated as the government department responsible for the

management and oversight of the newly established children's departments in England and Wales. However, it was the Treasury that held the purse strings; it settled the rate support grants to local authorities and the children's committee had then to battle for its share of the pot. There was no money ringed fenced for children's services coming into local authorities. The Home Office soon produced guidance (although not a huge amount by today's standards) and extended the size and role of the inspectorate. Requirements were imposed on professionals by means of statutory orders, rules and regulations which carried the same legal authority as the Act. These covered areas such as court procedures and the conduct of residential and foster homes. They not only specified correct behaviour but also reflected a diminution in the absolute power of parents to decide what was best for their child. Guidance, memoranda and circulars that did not have statutory power were also issued, although there was no equivalent of what is termed 'statutory guidance' that has recently appeared alongside new legislation.

25. Within these limits, officials and carers were fairly free to act as they thought best for children. Caseloads were large in the 1940s and 50s, usually around 50 but sometimes as high as 70, and there was only moderate supervision of staff by today's standards. In rural areas many of the boarding-out officers worked alone. They took children to their own homes, accommodated them in emergencies, transported them in their cars, gave them money from their own pocket and got them up for school. There had been numerous scandals of staff abusing children in the nineteenth century and in the 1940s and 50s there were incidents related to the harsh regimes (but not abuse) in approved schools, such as the Standon Farm murder in 1947 and the Carlton House riot in 1959. But, those working as child care officers in the 1950s and 60s who have published memoirs or spoken about the 'old days' at seminars and conferences recall that the possibility of physical or sexual abuse by them or colleagues never crossed their minds and none of them could recall a single incident let alone an inquiry. One reason for this was that the overriding concern was the neglect rather than the abuse of children.

26. Staff in residential homes and schools also had considerable freedom and although most behaved responsibly, a few abused their authority by imposing made-up treatments (as happened later in the 1980s with Pindown[v]) or taking opportunities to physically and sexually assault the children (as in the 1990s at Kincora and Bryn Estyn[vi]), many of these situations only coming to light many years after the events. The Home Office greatly valued its work with deprived children as it softened its public image of having responsibilities for apparently harsher issues like law and order, prisons and immigration. When the move of children's services to another government department was first aired in the 1960s, the then Home Secretary, James Callaghan, was reported as saying, "We lose children's services over my dead body". The child care service also benefited at this time from a cross-party agreement that children's services should not be the subject of party political dispute, an arrangement that prevailed until the 1970s.

27. Although after 1948 these new departments quickly consolidated separate strands of work, they had to start from scratch. The new children's officers

came from a variety of backgrounds. In the county boroughs, the appointments were mostly men who had previously worked as senior managers in Education Departments and so were familiar with the workings of local government and committee procedures. In the shire counties, many more women were appointed and they came from a wider variety of backgrounds; for example Frances Drake (Northamptonshire) had been a factory inspector in the Second World War[vii]. The smaller authorities tended to have fewer resources In the county borough of Dudley (then a county borough in Worcestershire), the first office accommodation was a caravan, travel around the borough was by bus and the children's officer's status within the organisational hierarchy was the same as the official responsible for weights and measures. But this contrasted with places like Birmingham and Manchester where large and well-endowed departments were soon operating.

Training

28. The Curtis Report had recommended a national programme of training for child care work in its Interim Report of March 1946 and opportunities began to be created in anticipation of the new Children Act[viii]. Hence the Home Office provided full-time courses for graduates at prestigious universities and trained them to become what were still termed boarding-out officers, awarding them a basic qualification, the Home Office Letter of Recognition. A Central Training Council was formed to coordinate all of this in 1947. This professionalisation led to a change in name in the 1950s from boarding-out officer to child care officer. However, the proportion of staff who were qualified remained relatively low (in 1960 28% of child care officers were trained) and was lower still for residential staff as at first their training was usually the responsibility of the local authority.

The nature of services

29. The nature of the services varied enormously across local authorities. In some areas, such as throughout Scotland, there had been a long tradition of foster care but as many of the placements were in the Highlands and Islands, a long way from most children's home area, this must not be assumed to have been a good thing. Elsewhere the new departments inherited run down former orphanages and workhouse buildings. The Second World War meant that maintenance had been neglected and building materials for renovation were scarce. Residential care, therefore, comprised a mixture of establishments from small family group homes run by a married couple who, with domestic help, looked after half a dozen children in a quasi-family setting, often in two council houses knocked into one, to institutions with as many as 50 residents. In 1964, the proportion of children in residential care living in children's homes in England and Wales that were registered for more than 12 residents was 66% but this had fallen to 47% by 1969. The rate remained stable in the 1970s because of the incorporation of larger establishments, such as former approved schools, and was 52% for England in 1988, However, there was then a dramatic fall to 13% in 1995 and 9% in 2000 confirming the general demise of the large institution. In 2013, out of the 1,718 registered homes for children in England, only four are licensed to accommodate more than 20 children.

30. The numbers in care at any one time settled in the 1950s and 60s to about 70,000 in the UK with around 30,000 annual admissions and departures. But there were marked differences in the proportion of all local children who were in care and in how they were dealt with. In England, rates in care ranged from around three per 1,000 children in prosperous areas to 27 in poor ones. Similarly, in 1964, the overall fostering rate in England was 48% but this varied from 78% in East Suffolk to 30% in Worcester. A study seeking to explain this difference found that in each local authority the child care officers accepted without criticism the policy prevailing in their authority, that is high use of foster care in one and high use of residential care in the other, indicating a lack of informed consensus or a wider vision about what was best for separated children[ix]. When Oxfordshire applied for central funds to open a residential reception centre for eight children in 1952, the Home Office replied that the number was far too small and, in any case, was not enough for a football team.

31. How does the situation described for the UK compare with that in Jersey? The following table compares legislation and major publications in each place[x] and some observations are added (in italics) by the authors, although it must be emphasised that they are not trained lawyers.

32. The full texts of the key legislation and supporting documents, such as rules, regulations and guidance, are provided in Appendix Three.

Year	UK	Jersey
1948	**Children and Young Persons Act 1933** in force and continues Provision for young offenders Registration and inspection of voluntary homes **Children Act 1948** Amalgamated three strands of provision Children's officers and committees appointed Central Training Council established Duty of local authorities specified Standards of treatment of children in care Rules re contributions to maintenance Operation of voluntary homes and organisations Child life protection Administrative and financial	**Children and Young Persons Act 1933** in force from 1935 by Order in Council Deals with: Offending Placement in a residential establishment Employment Court proceedings Provision of remand homes and approved schools *(No apparent requirement to board out or use fit person orders* *No mention of Borstals)* **Loi (1940) sur la Protection de l'enfance** Regulation of foster carers' duties and powers *(Provides monitoring of children under*

	provision Children Act 1948: Memorandum by the Home Office on the main provisions of the Act affecting voluntary homes and voluntary organisations in England and Wales: the Act designed to ensure that 'all deprived children shall have an upbringing likely to make them sound and happy citizens and shall have all the chances, educational and vocational, of making a good start in life which are open to children in normal homes'	*14 in foster care; age is 18 in England and Wales Child Life Protection legislation* *Nothing on the regulation of private nurseries* *Process of assuming parental rights same as 1948 Section 2 in England and Wales, i.e. by administrative fiat)* **Adoption of Children Law 1947** Defines infant as under aged 20 Approval of adopters Birth family's consent Wishes of child Financial liability *(Were there any war orphans in Jersey; they were an important group in the UK?* *Article 5 on maintenance: this was abandoned in England and Wales with end of poor law but continued in Scotland until 1970s. In Catholic European countries, it extends to relatives, especially grand parents)*
1949		
1950		
1951	**The Administration of Children's Homes Regulations** **Memorandum on the Conduct of Children's Homes (Home Office)**	
1952	**Children and Young Persons (Amendment) Act**	
1953		
1954		
1955	**Boarding out of Children Regulations** revised and extended accompanied by the Memorandum on the Boarding out of Children regulations (Home Office)	
1956		
1957		**Jersey Law: Modification of the**

		1933 Act Adopters receive benefit of any insurance policies on the child *(This was a major issue in the UK with respect to private fostering as it was thought to encourage baby farming and deaths. The 1908 Children Act banned foster parents from insuring the life of their foster child)* **Adoption of Children Amendment (Jersey) Law**
1958	**Adoption Act 1958** Tightened regulations on third party adoptions Registered agencies More formal process	
1959		**Adoption of Children (Amendment No. 2) (Jersey) Law 1959**
1960		
1961		**Adoption (Jersey) Law** Concept of protected child Duty on Education Committee to promote the well-being of protected children Inspection of premises Power to remove child in emergency Restriction on removal of infants for adoption outside the British Islands
1962		**Adoption rules**

1963-69
The 1963 Children Act

33. One major weakness of the 1948 legislation was that the children's department could only spend money on children once they were in care. The children's officers (now formed into an Association) and the growing profession of child care officers came to realise that this was a serious limitation and that more could be done to prevent admissions or to avoid bringing children to court. But the situation was that an expenditure on prevention was vulnerable to surcharge by the district auditor.

34. A change came in the 1963 *Children Act* which allowed local authorities to devote resources to prevent children from coming into care, thus broadening the remit of children's officers and laying the foundations for community care and family support that are characteristic of current practice.

35. This was an enormously important turning point that enlarged the tasks of children's departments. Of course, things did not just develop out of nothing and there were antecedents for this type of activity in the voluntary sector; the Family Service Units for example, a Quaker charity, employed staff to work in the homes of families under stress and join in the washing up and nappy changing.

36. The enthusiasm with which the new opportunities were taken up varied across local authorities. Some expanded but as extra money was not automatically made available to employ new staff, it depended on the local allocations within the overall financial budget, so the new work sometimes had to be shared among existing child care officers, causing some to complain that it diluted the resources that could be given to the children in care. There was also no special training offered. Nevertheless, the 1963 Act produced a major shift in priorities as well as administrative reorganisation and expansion.

37. Despite the consolidation of services for children in care, provision for the physically disabled and those with learning and behavioural difficulties were still largely separate, although such children did come in to care if families broke down. Education departments ran a range of special schools and local authority public health departments provided for the mentally handicapped, alongside a tranche of specialist provision for children with special needs run by voluntary agencies, although this declined rapidly post-1948. There were, however, some significant changes, such as a big fall and eventual disappearance in the use of residential nurseries reflecting the attention paid to the work of Bowlby, Tizard[xi] and others on the detrimental effects of institutional care for the very young. Also, the placement of disabled children in what were called sub-normality hospitals was coming under scrutiny following the publication of influential books like Erving Goffman's *Asylums* and Maureen Oswin's *The Lonely Hours*[xii]. These establishments were often huge, almost self-contained mini-towns with their own farms and gardens, and provided life-long care for children with what would now be termed learning difficulties or severe physical disabilities, as well for teenage girls defined as 'morally defective' in view of their becoming pregnant.

38. It was young offenders who gave the Labour Party in the 1960s a focus for setting the trend to incorporate different groups of children in need into a single legal and administrative system. Before 1969, young offenders had been dealt with by a process of supervision in the community (provided by both children's and probation departments, depending on local policies) leading for the recalcitrant (and for a few other groups such as persistent truants) to an order issued by magistrates for placement in an approved school, followed if this failed by a Borstal sentence for older teenagers.

39. Approved schools were mixed in terms of management: most were voluntary establishments run by the large charities, such as Barnardo's, the Salvation Army or the Rainer Foundation, or were run by a plethora of religious groups, such as orders of nuns and brothers and although largely funded by the Home Office (who carried out inspectorate responsibilities), they had their own managers. The Home office provided a *Handbook for Managers of Approved Schools* (1951) which dealt with a wide range of topics including punishment and appointment of staff.

40. By 1970, some were or had become the responsibility of local authorities. Around 10,000 children, 90% of whom were persistent male property (i.e. theft and burglary as opposed to violent crimes) offenders and 10% girls classed as in 'moral danger' because of their 'sexual promiscuity', were placed there at any one time. Most of the boys' schools had about 60 residents, those for girls were smaller, and stays often lasted for about two years[xiii].

41. The 1964 Labour government argued that these young people were, to use the language of the time, 'deprived' as well as possibly 'depraved' and needed more caring approaches. An opportunity to seek reform was seized in 1968 by the Home Secretary (Roy Jenkins) following revelations of excessive caning that broke Home Office regulations at Court Lees School in Surrey. The subsequent inquiry and dismissal of the headmaster greatly reduced the use of corporal punishment in approved schools but did not ban it because it was still legal in ordinary schools (see: *Administration of Punishment at Court Lees Approved School*, Report of Inquiry by Mr. Edward Brian Gibbons QC, 1967, Cmnd. 3367). This proved to be something of a challenge to those heads and religious orders, such as the De La Salle Brothers, who valued physical chastisement as an integral part of their educational philosophy. Having won this battle (there was a similar row when he overturned a magistrate's sentence for an inmate in Rochester Borstal to be birched), Jenkins laid plans to integrate the schools into the wider local authority residential provision available for children, a policy continued by his Conservative successor Sir Keith Joseph.

42. By the mid-1970s, all residential homes for children were called community homes and the former approved schools and some others which had facilities for education became known as community homes with education on the premises (CHEs and CHEPs in Wales). Most subsequently closed as services were reorganised and their provision came to be seen as isolated from wider social work, ineffective in providing what was needed and expensive to run. In Scotland they became List D schools. They remained unaltered for some time in Northern Ireland. In England and Wales, the need for a special residential order issued by magistrates was abolished and placement choice became a professional decision.

43. What is also important is that some politicians and magistrates saw this change as 'going soft on delinquency', thus threatening the consensus to keep child care out of party politics and the policy of separating juvenile delinquents from care cases. A change in the central administration of services was also questioned. In 1971, responsibilities for all children in care, including

young offenders in care, passed from the Home Office to the newly established Department of Health and Social Security, itself an amalgamation of two departments. Some critics expressed concern that the DHSS seemed to have a much weaker 'law and order' agenda than the Home Office. Similarly, in local authorities, child care became the responsibility of the newly formed social services departments that were introduced in 1971 following the recommendation of the 1968 Seebohm Report. These departments had a huge brief that included responsibility not only for children but also for the elderly and disabled.

44. The prevailing research interest in the late 1960s and early 1970s was on the effects of different residential regimes and a belief that results would vary for each type. But follow-up studies of re-offending rates among young offenders found more similarities than differences and concluded that most of the anti-social behaviour could be explained by other background variables. Until then, the Home Office had encouraged some experimental approaches, one of which was the 'short, sharp, shock' (a term borrowed from *The Mikado*) provided by detention centres and another the setting up of therapeutic communities, inspired by the Henderson Hospital model, at two former approved schools, Peper Harow and the Cotswold Community. These were transformed into something quite different from the old approved schools. The community of boys (they were both single-sex) and staff was seen as an essential part of the 'treatment'. Priority was given to communal meetings, where an individual's behaviour was discussed by the whole group, and to customised therapy for each individual. The provision was marked by a relaxed regime, supportive staff-pupil relations, good food, comfortable furnishing and opportunities to pursue personal interests, especially the arts[xiv]. But the history of these initiatives is typical of much child care: they had a belief based on a sensible theory but adopted a somewhat superior stance to the rest of the system and eschewed proper evaluation, preferring to rely on qualitative case studies. Sadly, lack of evidence to justify their high fees meant that they have struggled to survive economic downturns and reductions in local authority funding. However, a few establishments, such as the Caldecott Community and The Mulberry Bush continue to offer a specialist service for severely harmed children.

45. Further politicisation occurred in the mid to late 1970s with regard to race and ethnicity. It began in the approved schools that ran regimes based on a white working class culture in a context of full employment; that meant that boys did not swear in front of women, got up punctually for work, paid their mothers for their keep etc. In the late 1960s, schools serving the London and Birmingham regions began to admit large numbers of older African-Caribbean youths brought up by grandparents in the West Indies before joining their parents in England. Their demands and behaviour challenged the old order. For example, some wanted to retain their Rasta hairstyles and had different values and cultural expressions with regard to such things as punctuality and ways of showing respect to officials. All this began to challenge the fundamental values of the regimes. Indeed, the issue of cultural tolerance was to explode later in the decade when black social workers and birth families began to demand same race placements in foster care and adoption.

Nevertheless, it took a long time for the issues of ethnicity to be addressed; for example information about the ethnic backgrounds of looked-after children was not collected by the Department of Health until 2001.

46. These tensions were not restricted to child care. In society generally the 1970s saw growing inter-generational differences and declining religious observance, with compulsory church attendance removed as a requirement from the regulations governing foster and residential care. In residential care, it led to less emphasis on reform and re-socialisation to a moral ideal and more to an orientation to areas in which the outcomes have immediate practical use, such as educational achievement, social skills and coping strategies in terms of finding work and accommodation. As one Scottish List D school head said at the national conference in 1972, "With two million unemployed, I'm not worried that my boys can't play the flute". Proselytisation and reformist zeal had been significant in the past but were swept away by the force and speed of these social changes. Even the British public schools had to refine their long-standing belief in the merits of muscular Christianity.

47. The history of the approved schools provides a good example of a sea change in the influences on policy and practice. There was a concern about rising costs and a generally anti-institutional ethos across the developed world and for the first time the adverse effects of institutionalisation (institutional neurosis) were being charted. This had been suspected by the Curtis Committee who noted that many of the children in the places they visited were 'touch hungry' and 'desperate for attention'. In 1961, Erving Goffman wrote a provocative book on US mental health hospital care that described in broad terms the symptom of institutionalisation but these were categorised by the English psychiatrist Russell Barton into a recognisable clinical condition[xv]. He charted the defects and disabilities in social skills shown by people who had spent a long time in institutions cut off from the outside world, such as mental hospitals and prisons, and later extended to the armed forces, staff in boarding schools and religious orders. Such people are unable to exert independence and responsibility to the extent that they cannot cope with life outside the institution, even with simple things like cooking, laundry and self-care, let alone more complex aspects of life such living independently or establishing and maintaining relationships.

48. In addition, specific studies were conducted to a high scientific level (i.e. randomised controlled trials). One that was especially influential was the Home Office Research Unit's report, *Residential Treatment and its Effects on Juvenile Delinquency*[xvi]. The research randomly allocated boys to two contrasting regimes at Kingswood Approved School in Bristol, one a therapeutic community and the other a traditional training programme. It found similar rates of re-offending for both groups. In 1978/9, the Government thus agreed a policy shift and huge resources were devoted to community alternatives for young offenders called 'intermediate treatment'. It was inspired by the closing of all reform institutions for juveniles in Massachusetts, although the British version sometimes included a short residential experience as part of the programme.

49. Alternatives to residential care also developed for other groups, such as people with disabilities who were able to live at home and attend day centres. Family centres also opened across the country, often run by voluntary associations. There were two main types[xvii]: those to which children at risk of harm were referred for the purpose of family support, safeguarding and administering access arrangements, and those that offered a range of facilities to every family in the local community – open all hours, everyone welcome. There was no reliable research to evaluate the effects of either type of provision and as they are a targeted service in terms of clients and location, have been easy candidates for cuts and have opened and closed with considerable frequency. There has also been a lively debate between the 'helping families in a non-stigmatising way' argument versus one that raises fears about the dangers of 'congregating people with problems'.

50. But interestingly the application of psychological research did not always lead to positive change, as is illustrated by the history of residential observation and assessment centres. The Curtis Committee (1946) had endorsed the idea of providing reception centres for children coming into care, seeing them as the corner stone of the new service, and supported the prevailing psychological perspective that emphasised the benefits of a multi-disciplinary assessment to inform future plans. Reception centres were thus seen as a keystone of new provision as they could help children settle, assess their needs and move them on to somewhere suitable. But as more difficult adolescents, some of whom who would previously have been accommodated in remand homes, began to enter care following the changes introduced by the 1969 *Children and Young Persons Act* (implemented in 1971), a new set of establishments was needed and observation and assessment centres were opened across the country. These offered a six to eight week assessment leading to a placement decision. But criticisms of this arrangement soon arose: the setting was too artificial for an accurate assessment, it introduced an unnecessary placement change, eight weeks out of school destroyed children's education and, most devastating of all, nearly all of the final placement decisions could have been predicted on entry. Also, what was recommended could not always be realised. So, no sooner had these centres been established – they accommodated 5,300 children at their peak in the early 1980s – than they began to be run down (only 700 residents in 1995) and by 1998 had actually disappeared as a placement category in the government's annual child care statistics. A parallel decline also occurred in the old approved schools where between 1978 and 1990, three quarters of the 100 or so schools closed.

Year	**UK**	**Jersey**
1963	**Children and Young Persons Act 1963** Allowed expenditure to prevent admissions to care Parents no loner able to bring a child to court as beyond control	

	Age of criminal responsibility raised to 10	
1964		
1965	**Boarding-out of Children (Amendment) Regulations 1955**	**Adoption (Jersey) Law** Deals with adoption orders made outside Jersey
1966		
1967		
1968	**Seebohm Report** Integration of children's services into social services departments **Social Work Scotland Act** Set up the panel system	

1969-89

The 1969 Children and Young Persons Act

51. These recommendations for change were incorporated into the 1969 *Children and Young Persons Act* which was fully implemented by the mid-1970s. Apart from bringing more young offenders into the care system, it distinguished between voluntary care, where parents agree to a child being taken into care, the assumption of parental rights by the local authority and replaced 'fit person' orders with care orders by which a court makes the decision to transfer parental rights to a local authority. The Act also redefined the grounds for making care orders - abuse and neglect (actual or likely), moral danger, beyond control, truancy, offending and matrimonial family problems.

52. The important point for practice in England and Wales was that it changed the way decisions were made about young offenders who previously would have been given an approved school order. It extended to them the arrangement of making care orders and a specific 7(7) order was introduced, so handing responsibility for care placement decisions from courts to professionals. As mentioned earlier, this was not so in Scotland where panels retained that power.

53. The inclusion in the care system of a large group of young offenders not only led to a huge increase in the numbers in care (the in-care population in England rose to nearly 100,000 in 1977), but also altered the age distribution (over 50% of admissions were over secondary school age). It thus made demands on expensive resources. But despite this initial pressure, the care system coped and things eased as the young offender cohort aged-out of the system. Thereafter, all types of residential care began to decline across the country once alternatives had been established. Warwickshire was amongst the first to announce the closure of all its facilities in the mid-1990s, although

there was a suggestion that its use of special boarding schools increased as a result[xviii].

54. The 1969 Act also set off an important ideological debate about how to deal with offenders. In making such children subject to a care order, the link between the nature and severity of their crime and what happened to them was broken. This had long been an ambition of the Labour Party and was the recommendation of the influential report of 1964, *Crime: A Challenge to us All*, prepared by Lord Longford written when the Party was in opposition. It reflected a view that the causes of crime were largely social structural rather than due to offenders' weakness of character and that the old system of dealing with them was stigmatising and counter productive.

55. But lawyers are rarely inactive and concerns soon arose about the new perspective on youth offending and court disposals, especially committal to care. While few denied the importance of deprivation and poor self-esteem in explaining delinquency, the ethical problem was that for the same offence, a very deprived child might stay in care for a long period, whereas one from a good home might return home quickly or even not be separated at all. The Justice for Children movement highlighted this inconsistency vociferously during the 1980s[xix] and in 2003 the Labour Government reinstated the old system and directed young offenders down a different route, namely to the newly established Youth Justice Board. This introduced a more overt tariff system based on the nature of the offence and restricted the range of details in the young person's background that should be considered by the court before passing sentence. The new Board also took over the employment of probation officers who had worked with juveniles as well as the running of former prison department facilities for young people and the secure child care units that had been run by local authorities. They combined all this provision into what became called the 'secure estate'.

The 1975 Children Act and rising concerns about child protection

56. Two other concerns bubbled away underneath the furore about offenders. The first focused on children who stayed in care for long periods or who had no hope of returning home. An influential study published in 1973 by Rowe and Lambert, Children who Wait[xx], identified a group of children who lingered in care without plans being made for a stable family placement. Thus, the concept of 'drift' entered the child care vocabulary and adoption was seen as an option for these children; but the process for this was complex and slow. The 1975 Act aimed to eliminate 'drift' and simplify the process of finding the children long-term families by speeding up the process, 'freeing' children for adoption before a family had been found and widening the activities on which money could be spent. It was influenced by the concept of 'permanence' developed by Tony Maluccio and others in the US[xxi]. It was also inspired by the pioneering work of reformers such as Jane Rowe and Nancy Hazel who showed that children previously considered 'unfosterable' – adolescents, disabled, behaviourally difficult, black children and groups of siblings - could be found permanent families if sufficient effort were made. This legislation is significant in that it reduced the ability of parents to block adoptions and thus

represents a shift from parental rights to the rights of the child. Although little used by foster parents, the provision for custodianship – not introduced until 10 years after the parent Act – offered another option for 'hard to place' children.

57. The second concern was about the protection of children at risk of harm. Just as the Dennis O'Neill scandal arose during discussions about changes to policy, in 1974 the child care system in the UK was rocked by the death of a young girl, Maria Colwell, at the hands of her mother's violent partner[xxii], especially as she had been returned from care to live with her mother after the court had discharged the care order. Up until then, people were aware of the effects of abuse and neglect and did what they could to prevent it, but knowledge was scant and a general rule of optimism prevailed. In addition, in the 1940s and 1950s the term 'child protection' referred specifically to the supervision of children in private foster homes.

58. A public inquiry was held into the death of Maria Coldwell. The report was critical of the lack of coordination between different health and welfare agencies. It recommended establishing formalised inter-agency systems for dealing with child abuse. This recommendation was implemented across the UK.

59. The wider context was also different from today. Up to the 1960s, children were smacked at home and beaten at school, violence to women went unattended, although it was never socially approved, and sexual assaults often went unrecorded, let alone uninvestigated. But although there was a history of expressed concern and legislation about abuse, whether in families or in the care system, there was no clear process to investigate it and thus responses were unpredictable. The NSPCC was the most active voluntary organisation but there was no equivalent to the Child Safeguarding Boards that operate today.

60. There were dozens of inquiries in the nineteenth and twentieth centuries into abuse in residential care. The problem was that these never achieved publicity in a way they would today, and although the reports exist, they are often closed under the 100-year rule because they name children. Hence, it is unclear whether the revelations from the 1970s indicate an increase in the amount of abuse or changes in responding to it, especially the role of the media and investigative journalism. Nevertheless, the Maria Colwell case highlighted questions still being debated today. How long should known abuse and neglect be allowed to continue? What is the threshold for removing a child? What if the mother and child love each other but another family member is the abuser? It also set off a process of holding public inquiries that now attract considerable media attention.

61. New knowledge about the effects of abuse and neglect was also emerging and an influential concept from the US in the mid-1970s was the 'battered baby syndrome' which alerted people, including medical staff, to domestic violence as a possible cause of injuries[xxiii]. There was also at this time concern about

'battered wives' but it was some years before older children and issues such as emotional abuse and neglect attracted attention.

62. Since then, as will be explained, knowledge, tolerance and practice of child abuse have changed radically and child protection has risen to dominate current thinking, policy and practice[xxiv].

63. When a comparison is made with the situation in Jersey, it can be seen that there are parallels with the regard to the 1969 Acts but not the 1975 Act.

Year	UK	Jersey
1969	**Children and Young Persons Act 1969** Repeal of 1933 Children and Young Persons Act Amalgamation of children's departments into wider social services departments New criteria for making care orders in pace of approved school and fit person orders Professional discretion over placement of offenders (not Scotland) Young offenders brought into care system Closure of approved schools and integration into residential provision Opening of O and A centres Children's Committee oversees service and does not make decisions on cases Creation of community homes with education on the premises **The Castle Priory Report: Residential Task in Child Care** Discusses the training needs of staff and optimal staff:child ratios	**Children (Jersey) Law 1969** Repealed 1933 Children and Young Persons Act Employment Safeguarding from moral and physical danger Safeguarding powers of the Royal Court Protection of children in judicial proceedings for offending Powers to deal with serious offenders Protection of children in family proceedings Protection of foster children Nurseries and child minders The conduct and inspection of voluntary homes Duty of committee to assume the care of certain groups of children Role and duty of the Treatment of Children in Care Committee Contributions toward maintenance *(Article 9(5) seems to permit corporal punishment* *Article 24 is first mention of fit person order and Article 28 of supervision*

		order *Article 80 on voluntary homes – which voluntary organisations were/are active in Jersey?)* **Children's Benefits Funds Law 1969** *(In the UK, no special fund was allocated, it was up to the local authorities to fund services from domestic rates and rate support grants, but there were occasional payments ultra vires)*
1970	**Local Authority (Social Services) Act 1970** Establishment of social service committees Creation of directors of social services	**Children Boarding-out Order** Recruitment of carers and management of placements *(Article 8, visits to foster homes from 'time to time'; in the UK intervals are specified)*
1971	**Children and Young Persons (Definition of Independent Visitors) Regulations 1971**	
1972	**Community Homes Regulations 1972** Creation of community homes with education in place of approved schools	**Children (Amendment) Law** Removal of power to send a child to an approved school
1973		
1974		**Children (amendment no.2) Law** Creates juvenile appeal court
1975	**Children Act 1975**	

	Facilitating family placements and adoption for children Shift from parental rights to rights of the child	
1976	**Adoption Act 1976**	
1977		
1978		
1979		**Children (amendment no.3) Law** Replaces 'detention centre' with 'young offenders centre' Raises age of entry to 21 Replaces approved school order with 'place of safety' Abolishes prison for under 18s
1980	**Child Care Act 1980** Largely consolidating but tightened regulations on private fostering **Foster Children Act 1980**	Inspection by Social Services Inspectors from England. Ninety-nine recommendations made for improvement in: General policy Premises Workload Staff roles Monitoring and case reviews Fostering Adoption Child Abuse Day care for under 5s School attendance Juvenile delinquency Residential provision Haut de la Garenne Staff development
1981		
1982	**Boarding-out of Children (Amendment Regulations) 1982**	
1983		
1984	**Short Report on Children in Care**	

	Highlighted domestic violence as a risk of harm to children Recommended reorganisation of social work services into a national social services inspectorate	
1985	**Publication of Social Work decisions in Child Care** First of a series of 'Messages from Research' overviews based on a government funded research programme (Series has continued to 2013) Topics covered have included: Child placement Residential care Adoption, Child protection, Supporting parents	
1986		
1987		
1988	**Boarding-out of Children (Foster Placement) Regulations 1988**	

1989-present day
The 1989 Children Act

64. With all these balls in the air and the growing amount of inspections and research revealing fragmented services, unsatisfactory performance and poor outcomes, there was a need for a radical rethink about how legislation could satisfy all these demands. The solution came in England with the 1989 *Children Act*.

65. It is impossible to describe this radical and comprehensive law in detail but some salient points will be offered. Initially, it followed reviews by several important bodies, such as a Parliamentary Committee (Short Report)), the Law Commission and the Department of Health's own *Review of Child Care Law* and energy of individuals such as lawyer Brenda Hale and civil servant Rupert Hughes. It also took notice of the considerable amount of research that had become available in the 1980s and was seen as highly 'research informed'. This knowledge was not just confined to informing the Act, but was expanded in the volumes of guidance that accompany it; these are almost text books in their own right. This means that the Act cannot be read in isolation.

66. The 1989 Act was a mixture of consolidation and radical reform. In terms of consolidation, it integrated public and private law and brought day care into

line with other services, even though the Act is not usually seen as consolidating legislation.

67. In terms of radical changes, however, the impact is more obvious. It abolished the plethora of conditions to take action and in their place set several underlying general principles: the child's welfare must be paramount (a forceful word that had been hinted at but not used before in legislation), children were to be perceived as 'being in need' in the sense that their health and development would be impaired if no services were offered, the criteria for judging this should be the risk of harm or significant harm (a checklist to assess this was published), action should not be taken unless it could be shown to improve the child's situation (the least detrimental alternative), children' race, religion, language and culture should be respected and the child's voice should be heard at all times, with assistance from a sympathetic adult if necessary.

68. Philosophically, the change was important too. Although the final vestiges of the Poor Law had long since disappeared from child care, the 1989 Act finally sealed its coffin by combining private and public law, thus providing an approach to serve all children on the basis of their needs. Similarly, the Poor Law had been funded by local taxes and parishes had been eager to minimise costs and avoid taking on cases from elsewhere by constructing eligibility criteria and barriers to obtaining a service. Again, although this issue was not a significant deterrent to practice, the new Act emphasised that children should get what they need, as they would in the NHS in a manner unfettered by financial and administrative complications. It is important to note, however, that while one fundamental principle of the Poor Law - the principle of less eligibility whereby those benefitting from public services should not be better off or more comfortable than other people outside - was no longer important in child care, it continues to be a contentious matter in social security with arguments about whether financial benefits should be allowed to exceed income from employment.

69. The 1989 Act also dropped the use of pejorative terms, such as 'in care' and 'handicap', introducing less stigmatising ones, such as 'looked-after' and 'disability'. In combining private and public law, it emphasised that any child can be 'in need', not just those from poor families, and that both would be dealt with in the same way. It also abolished the ability of local authorities to assume parental rights and responsibilities by administrative fiat, that is without recourse to a court, a power that had existed for 100 years. Finally, it attempted to answer two criticisms of the earlier care system made by Jean Packman, John Triseliotis[xxv] and other researchers, namely that it was too much of an 'all or nothing' service and more was needed in-between, and that for children and families it was a punitive experience that deterred people from seeking help and de-skilled those who did.

70. Some of the details based on these principles are important. Courts could now make orders from a range of options, not just care orders but assessment, contact, residence and prohibited steps orders. Some of these obviously limited professional choice, but apart from those, any selection was possible

from a spectrum of services, depending on the needs of the child, thus achieving the best match between needs and services. However, this did not mean that social workers had a completely free hand as there are always questions of cost and availability. So, as with so much previous child care legislation, the new arrangement was more about setting a tone and emphasising a perspective than offering something radically different. In addition, it is important to note that care orders did not open the door to specific services, they merely allowed professionals to act in the child's interests. In contradiction to a popular misconception, it did not institute a separate child protection 'service'. Neither did care orders completely remove parental rights, so retaining some element of shared care. In the past, child care officers had considerable discretion, even if they were not officially given it – so the significant point about the 1989 Act is that it recognised this discretion as important and enhanced it.

Legislation in Jersey

71. So to move to Jersey legislation, it can be seen that thirteen years after the UK reforms, there was a shift from the 1933 Law, which focused mostly on offenders, to the more comprehensive *Children (Jersey) Law 2002* in terms of the range of children it covers and the scope of its remit.

72. Much of it echoes the 1989 Act in England; for instance in Article 2(1) 'the child's welfare shall be the court's paramount consideration'. There is also a specification in Article 2(2) to reduce delay, and in 2(3) to take account of the child's wishes, to adopt a broad needs perspective, to note any risk of harm and to look at all options and their likely effects, to seek the least detrimental alternative and to assess any strengths in the child's extended family.

73. Further detail in Article 3 of the Jersey legislation defines who can have parental responsibility, given the diversity of contemporary family structures, and Article 7 ensures the child's right to have a guardian nominated. Article 16 allows for family assistance. In addition, the orders available to the court (Article 10(1): residence, contact, specific issue and assessment (Article 36), are again similar to those in the UK.

74. In Part 3, however, there is something unique to Jersey where the role and responsibilities of the Minister and, before 2002 the Education Committee that held responsibility for child care, are elaborated. Both have been and are seen as the providers of services and have responsibilities to oversee the child's situation. Without knowing the Jersey system (and Jersey is a small authority so presumably a small group of professionals know one another and have opportunities to reach decisions informally), it seems that the Committee system was a continuation of the 1948 Act arrangements in England and Wales where the local authority children's committee had to sanction key decisions, such as assuming parental rights. The original Article 24, for example, says 'the Court on the application of the Committee may make a care order placing the child....in the care of the Committee' but since has become the 'care of the Minister'. Arrangements for decisions on individual cases were abolished in England and Wales in 1969 and social services (now

children's services) committees merely oversee the whole service rather than approve specific decisions about children, although since 2000, Governments have encouraged elected members to be more closely involved in services and have requested that a specific councillor be nominated to do this, as was original the expectation of the chair of children's committees.

75. The 2002 Law also deals with specific issues, for instance Article 22 on secure provision, contact between child and birth family (Article 27), applications to discharge orders (Article 33), emergency protection (Articles 37-43) and abductions (Articles 44 and 45). It also requires registration and oversight of voluntary homes (Article 54) and management of private fostering arrangements (Article 58). Court procedures are covered in Articles 67-76), although there appears to be no provision for the appointment of a guardian ad litem. Financial arrangements are dealt with in Schedule 1.

76. Although the Jersey legislation is underpinned by the overarching welfare principle, some of the detail is different from the 1989 Act in the UK. There appears, for instance, to be less emphasis on the requirement to fashion a multi-disciplinary approach. The Jersey legislation is also less clear about what exercising parental responsibility actually involves and there appears to be less concern about promoting the welfare of children not in care, for example by providing day care for the under fives. The categories of residential home that have to register are more restricted than in the UK and the arrangements for reviewing children's progress more flexible. It may be that extensive detail is deemed unnecessary given Jersey's small size, but the result is that some of the Articles come over to the outside reader as a bit more vague than their 1989 UK equivalents. It means that, in theory, there could be discrepancies between different Articles, such as when there is no one officially appointed to help the child through the court process; but the reality is that given the size and compactness of the island, this may be someone in the same office. This makes it difficult for an outsider to know what actually happens in practice.

77. With regard to the actual services that children experience, two sets of regulations seem especially apposite. The *Children's Homes Regulations* of 2001 (passed in England) emphasise the welfare principle and standards of care, protection from abuse and a duty to promote education but most of the text is devoted to the internal running of the establishment. Only Section 12 on the care plan discusses the links with other family services, expectations for the child's future and liaison with other professionals. Again, the local context might make it unnecessary to specify more detail but the result of this is that the ethos of the regulations comes over as somewhat institutional rather than as seeing residential care as a positive intervention within a comprehensive service.

78. The Jersey *Child Placement Regulations 2005* cover the procedures for selecting a placement for a looked-after child. They, again, emphasise the welfare principle and specify features that should make the placement a success. But, as before, while there is some provision for supporting foster carers, there is little on the positive contribution they might be able to make to

the child's life. In the text they come over as relegated to a tending role rather than as trained and supported front line agents.

79. Some of these impressions were picked up in the inspection report of 2012 prepared by the Care Inspectorate, the successors to the Social Work Inspection Agency. The Care Inspectorate found an auspicious context with 'committed and skilled front-line staff' who 'worked well together'. But there were criticisms that some residential and foster carers were undervalued and not involved in discussions about children. Some children also felt ignored when they expressed a view or complained. The lack of performance measures was also noted with consequent doubts about the arrangements for system management and quality control. This is in contrast to England where there are now regular surveys of children in need, comparisons across local authorities of outcomes for looked-after children regarding such things as educational attainments, emotional and behavioural difficulties, physical and mental health, substance abuse and offending.

80. A follow-up inspection by the Care Inspectorate in September 2013 found that many improvements had been made regarding the 14 earlier recommendations. In seven cases, there had been major changes for the better and in two others good progress had been made. In five other cases, however, the situation still needed attention. The good points were the new structure and sense of purpose and direction it gave staff, better service planning centred around six outcomes for young people, the incorporation of diverse recommendations into a single strategic plan, better corporate plans to ensure child protection, listening to the views of children, efforts to improve the confidence and status of residential staff and better arrangements for out-of-hours contact.

81. In two other cases, things were improving but with more work needed. These areas were: developing a comprehensive commissioning strategy and gathering basic information on children's backgrounds and progress.

82. Five areas were still causing concern. There was still insufficient evidence about the impact of services and how well they were meeting targets and aspirations. An effective performance management system, although in embryo, had yet to be implemented. Although complaints from children and other users were heard, they were still not addressed and incorporated into planning. There was a marked absence of any vision for residential care and manuals of procedures to help staff work effectively were not available.

83. Another review, this time of services for children and young people with complex and additional needs, was undertaken by the charity Action for Children, recommended more inter-agency cooperation, the development of prevention and early intervention services, attempts to set joint working practices and objectives, reorganising the relevant social work teams, promoting a personalised approach and reviewing legislation and guidance. It also echoed the earlier inspectors by suggesting better ways of listening to users, collecting appropriate information and developing new services, such as early family support and short-breaks care.

84. The Jersey Children's Policy Group has been attempting to incorporate the recommendations from all these reports into an overall service improvement strategy. They have reviewed the progress made with regard to 60 recommendations and produced action plans accordingly.

85. As the 1989 Act in England and the 2002 Law in Jersey and the accompanying rules and regulations cover such a wide area (although they say little on juvenile justice, family courts or adoption) and try to reconcile the contradictions that have been discussed, it is inevitable and correct that there has been continuous debate about the strengths and weaknesses of the approach. However, when the detail of the 1989 Act in England has been intensively scrutinised, such as in the two reports on the quality of child protection services by Lord Laming, the special edition of the journal *Children's Services*, the overviews of children's serious case reviews produced by the Department of Education and the recent Munro Report on child protection, the fundamentals of the Act have been judged sound[xxvi]. This does not mean, however, that the care system is perfect as illustrated in criticisms by Michael Little that the system is still unethical with regard to consent, rights and scientific authority and that what is actually offered is often at odds with the needs of children and families[xxvii].

The significance paid to child protection in England

86. Most of the controversies since the mid-1980s have concerned child protection and whether legislation is too sympathetic to dysfunctional parents or action is delayed for too long. The various inquiries illustrate this: those analysing the circumstance leading to the deaths of Victoria Climbié and Peter Connelly criticise professionals for failing to respond to clear indicators of abuse, whereas the Orkney and Cleveland reports criticise them for acting too precipitately[xxviii].

87. As child abuse can be identified by a number of different services, such as health, social services and education, and individuals, in 1995 the Government issued guidance, *Working Together*[xxix], to strengthen inter-agency cooperation. Because of separate agency budgets, domains and restrictive practices, the failure to collaborate had long confounded effective practice. At the same time, the Government launched a refocusing strategy to address the problem of achieving better integration between child protection and family social work. Research studies had shown that the vast majority of referrals for abuse and neglect did not lead to the removal of the child but to the provision of help via family support. It was felt that this should not be lost because of the influence of a few extreme cases. *Child Protection: Messages from Research*[xxx] was an important publication in this respect.

88. While no-one wishes children to be harmed, there were several sub-agendas in this policy shift. First, child protection has given social workers a clear role and status; this should not be underestimated as in 1981 an influential book had asked *Can Social Work Survive*?[xxxi] Second, the policy in England and Wales seems to have been driven more by developments in the US than those

in Europe where child protection practice is rather different (in Scotland more Scandinavian influence is detectable). The researcher Matt Stagner[xxxii] has explained that in the US, the protection of an individual's rights is enshrined in the Constitution and there is a more individualistic social ethos.

The New Labour Government of 1997

89. Labour's convincing election victory in 1997 heralded an extensive welfare programme but, perhaps surprisingly, with regard to children in care, it tended to accept the existing system set up by the 1989 Act but tried to make it work better. Thus, in England there was legislation in 2000 to increase the support of care leavers up to the age of 21, in 2002 to revise the arrangements for adoption, in 2008 to improve the availability of accommodation for looked-after children and to ensure that health and education were considered in reviews, and in 2010 to encourage even stronger approach to their education.

90. In Scotland, the most recent legislation, *Children and Young People Act (Scotland)* 2014, strengthens after-care and introduces arrangements for continuing care. The new Labour government did, however, introduce some high profile changes to ram home its intentions. One of the first areas to be affected was adoption and the Prime Minister gave his personal commitment to speeding up the process and reducing restrictions on applicants. This has continued with the number of adoptions from care in England rising from 1,600 in 1978 to 3,980 in 2014, and with groups previously excluded, such as gay and lesbian and single parent adopters, now eligible. A second was the transfer in 2007 of responsibility from the Department of Health to the newly titled Department for Children, Schools and Families. This integration with education also occurred at the local level with the incorporation of the sectors of social services departments concerned with young people and families into larger children's services departments which included education and which are often managed by someone from an educational rather than a social work background. The staffing of these department is now dominated numerically by teachers and classroom assistants with, in a typical local authority with a population of one million, social workers forming only 4% of a workforce of 15,000 directly involved with children.

91. In addition to revised legislation and guidance, several publications on looked-after children, such as *Care Matters* in England in 2006, *Children First* in Wales and *Getting it Right for Every Child in Kinship and Foster Care* in Scotland[xxxiii], reinforced the earlier messages about the welfare of each child being paramount and to carry on doing more of the same, but to do it well. One method specified in the England document was family group conferences which received approval in *Care Matters* despite a lack of evidence to show their effectiveness, again illustrating the uneasy combination of belief and science that has marked this field for so long.

92. Labour's commitment to children was considerable but its most radical innovations tended to cover broad areas, such as the welfare of all children, as manifest in the publication *Every Child Matters*[xxxiv], the reduction and eventual elimination of child poverty, early years prevention (the creation of

SureStart[xxxv]), pre-school education, better school facilities, modifications to school curricula and investment in health and leisure, all supported by other changes, such as higher financial benefits, a minimum wage and better child care supports for working parents as part of its Welfare to Work programme.

93. Children in care benefitted from improved chances of having a better time while there in terms of experiencing choice, protection from abuse, an allocated professional and easy access to outside help, such as Childline, as well as from extra money to assist with their education and life after leaving care. To encourage this, the Government set cross-agency standards. One of these was the Assessment Framework[xxxvi] designed to help different professionals chart the needs of children and families using an 'ecological' model. It also issued extensive and detailed guidance on almost every aspect of the work and instituted an integrated system of recording children's needs and experiences to be used by all agencies. Unfortunately, this bureaucracy proved so overwhelming that it produced a counter reaction from professionals who felt that the excessive control over activities and the demand for paperwork was displacing direct work with children and families[xxxvii]. Social work was being reduced to a dehumanised tick-box approach – in great contrast to the early child care officers in the 1940s and 50s who had considerable professional discretion, did what they felt right and kept scant notes. But the Government argued that the new system was necessary because cases were now so complicated and the threat of litigation so real, it was necessary to ensure that when making decisions, all factors known from research to be possibly significant were considered in a consistent way and that decisions and reviews would reflect this.

94. Paradoxically, increasing central control was accompanied during this period by a rise in the number of independent (i.e. for profit) and voluntary providers. For example, in England in 2013 there were 407 private and voluntary children's homes and 229 independent fostering agencies which when added to provision in the 152 local authorities, means that there were 788 agencies involved in the care of looked-after children, challenging the quest for better coordination. In some local authorities, over half of foster placements and nearly all residential ones are purchased from outside commercial companies, indeed the rates for the whole of England are 36% of all foster placements - excluding those with relatives and friends - and 72% of all registered places in residential settings. When this change is coupled with the growth of academies and free schools in education, the changes have seriously weakened the ability of local authorities to influence what goes on within their areas. In the past, the voluntary sector was always more freewheeling and difficult to control and until the 1930s there was no automatic registration and inspection, and what control there was came via grants from central or local government. Although there is now more oversight, it remains difficult to impose national policies on the independent sector or even to know what is happening - witness the different amount of statistics available about the public sector compared with the private.

95. It has almost passed unnoticed that in 2013, Part I of the *Children and Young Persons Act 2008* was commenced that allowed local authorities in England to

delegate service functions for looked-after children to a third party provider, and that there had already been pilots, such as Virgin Care in Devon. But now, via these new regulations, the government wishes to extend this to all children's services.

96. The results of all these changes are still being assessed. Some have clearly been beneficial but others less so. For example, many respected and innovative organisations, especially community facilities and therapeutic residential centres, have been curtailed or closed down after the financial crisis of 2008 and there was a large increase in admissions of older adolescents (under 18s) to young offenders institutions around the turn of the century, although, remarkably, this has dropped by two-thirds in the last four years, emphasising the dangers of drawing conclusions from short-term comparisons.

The situation since the election of the 2010 Coalition Government

97. Although not hostile to children's services, the Coalition government since 2010 has generally let things carry on with the focus mainly on education and schools. There has been one symbolic change in England: the speedy dropping of Children, Schools and Families from the name of the responsible Government department, which is now just the Department for Education. There has also been a specific policy to increase further the number of adoptions from care and make the process quicker and simpler and reports on child protection services and prevention strategies were commissioned from Eileen Munro and Graham Allen respectively[xxxviii]. Otherwise local authorities have been left very much alone in terms of policy and practice, except in those places where the Government's inspection arm, OFSTED, has found poor standards. There have also been some interesting innovations, such as he creation of 'virtual heads' and transferrable funding to improve the education of children in care. But, it is generally fair to say that there has been no dramatic shift in ideology about what is done, in contrast to ideas about how it is done, and the Government has shown little interest in commissioning radical research. But what has hugely affected local authorities is the large reduction in central Government funding. As a result, many services for children and families have been withdrawn and plans have been abandoned. There were 3,632 SureStart centres in England in 2010 but only 3,116 now, a fall of 14%. More significant, and in contrast to former years, costs and 'value for money' have become a central issue when making decisions such as choosing an out-of-area placement in a residential school or secure unit.

YEAR	UK	JERSEY
1989	**Children Act 1989** (in force 1991) Published guidance provided Clear principles: Child's welfare paramount Match needs to services New concepts:	

	Children in need Significant harm Least detrimental alternative Respect race, religion and culture Child's voice to be heard Spectrum of services New terms: Looked-after children Disabled Administration: Combined private and public family law Reduced barriers to services Parental rights via court New range of court orders Professional discretion after court order made **The Care of Children: Principles and Practice in Regulations and Guidance** **The Utting Report on Residential Care** **Report on removal of children from families in Orkney**	
1990	**Community Homes (Control and Discipline) Regulations 1990**	
1991	**The Children's Homes Regulations 1991** **The Arrangement for Placement of Children (General Regulations) 1991** **The Foster Placement (Children) Regulations 1991** **The Placement of Children with Parents Regulations 1991** **The Contact with Children Regulations 1991** **The Review of Children's Cases**	

	Regulations 1991	
1992	**The Warner Report: Choosing with Care** Report of a Committee of Inquiry in to the selection, development and management of staff in children's homes	
1993		
1994		**Protection of Children (Jersey) Law**
1995	**Major revision of Working Together in Child Protection** **Publication of Child Protection: Messages from Research**	**Children's Order, Northern Ireland** Introduced changes similar to the 1989 Children Act in England **Transfer of Functions (Health and Social Services) Act** Functions of Education Committee under Adoption Act 1961 and Children Jersey Law 1969 transferred to Health and Social services Committee but Education Committee retain some functions of the 1969 Act **Residential Homes (general provisions) Jersey Order** Specifies conduct of homes
1996		
1997	**People Like Us** Review of safeguards in residential care	
1998	**Publication of Quality Protects**	
1999		**Age of Majority (Jersey) Law** Reduces age of majority from 21 to 18 Power to assist young persons previously in care

2000	**Assessment framework published** Legislation to increase support of care leavers to 21	
2001	Responsibility for young offenders moved to Youth Justice Board **Children's Homes Regulations 2001** Welfare brief Appointment of managers Recruitment of staff Ensure education and health Safeguarding policy Respects privacy Respects culture and religion Need for a plan Contact arrangement Permitted controls Complaints procedure Record system Fitness of premises	
2002	**Adoption and Children Act**	**Children (Jersey) Law 2002** Repeals Children (Jersey) Law 1969 Principles: Child's welfare paramount Child's wishes heard Needs-led services Least detrimental alternative All options considered Redefines who can have parental responsibility Redefines roles of the Minister and Committee Revised arrangements for secure accommodation, family contact, emergency protection and abduction. Registration and oversight of voluntary homes and management of private fostering arrangements
2003	**Appointment of a Children's**	

	Commissioner Followed the recommendation in the abuse inquiry in North Wales for an independent ombudsman-type official **Publication of Every Child Matters** **Report on death of Victoria Climbié**	
2004		**Protection of Children (Amendment No. 3) (Jersey) Law 2004**
2005		**Children Rules 2005** **Children (Contact in care (Jersey) Regulations 2005** Reemphasises the welfare principle Sets standards of care Protection from abuse Importance of education **Child (Placement) (Jersey) Regulations 2005** Procedures for making a placement **Child (Secure Accommodation) (Jersey) Order 2005** **Children (Voluntary Homes) (Jersey) Order 2005** **Children (Parental Responsibility Agreement) Rules 2005** **Children (Prescribed Classes of Applicant to vary Decisions) Rules 2005** **Child Custody (Jurisdiction) (Jersey) Law 2005** **Child Abduction and Custody (Jersey) Law 2005**
2006	**Publication of Care Matters,**	

	Children First and Getting it Right for Every Child	
2007	Transfer of responsibility from DH to DCSF Social Care Institute for Excellence established	
2008	**Publication of Munro Report on Child Protection** Legislation to improve health and accommodation of children in care Children and Young Persons Act Enhances the contracting out of services	**Williamson Report on Child Protection** External review Role of residential care New management structure **Howard League report on Youth Justice in Jersey** Ratify UNCRC Child specific policy Preventive services
2009	**Report on death of Baby Peter Connolly**	
2010	Change of name of Government Department to Education **Children, Schools and Families Act** Legislation to improve education of children in care New arrangements for special educational needs, disabilities and family proceedings	
2011		
2012	College of Social Work established	**Inspection report by Social Care Inspectorate** Skilled front line staff but residential and foster carers undervalued Children felt their views ignored Lack of performance indicators **Action for Children Report on Services for Children and Young People with Complex and**

		Additional Needs More inter-agency cooperation, More prevention and early intervention Joint working practices and objectives Reorganising relevant social work teams Promoting a personalised approach Reviewing legislation and guidance and developing new services
2013		**Follow-up Inspection report** New structure, better planning, children heard, residential staff supported and better out-of-hours contact. But, commissioning strategy, recording of information, evaluation, complaints procedures, vision for residential care, training manuals and performance management system still need attention.
2014	New Adoption Act in process Legislation in Scotland to improve continuity of care	**Children's Policy Group** Review of and plans for implementation of 60 recommendations in previous reports

Changes in child care since 1945: three general points

98. This quick Cook's tour of post-War child care history is inevitably selective but before drawing out some general themes and trend, several points need to be made to clarify the discussion.

99. When comparing 'then' and 'now', it is important not to romanticise the past. Resources were scant, practice was variable, abuse went under-reported and outcomes were unknown; but some of the relational element of the old children's departments has undoubtedly been lost and social work has become

more structured and bureaucratic. However, if you take one area – the education of children in care – changes for the better are vivid, as manifest in Sonia Jackson's recent book on this topic[xxxix]. It was scarcely an issue thirty years ago but is now funded and planned to a sophisticated degree, with a 'premium plus' extra to school for each looked-after children on its roll. On the other hand following the Southwark judgement that voluntary care should be used to accommodate homeless 16-18 year olds, the latest evidence suggests that these young people tend to be placed in B & B or lodgings rather than the professionally staffed hostels of former years[xl].

100. A second commonly asked question is: are children in care more 'difficult' than in the past? As a population, in the UK at least, children in care today are more 'difficult' in terms of their presenting problems and/or behaviour. This is to be expected as preventative services are more effective, there are alternatives to care and problems that commonly led to a child's admission in the past, such as poverty, eviction, mother's confinement, non-school attendance, beyond parental control and petty delinquency, are dealt with in other ways. Thus, the 'easy' cases are filtered out. We also have better understanding of and are more sensitive to the effects of abuse, trauma and separation, the difficulties of attachment and identity and the causes of disabilities. Children and families also have more rights, making processes more complex.

101. But, and this is the important point, at the level of an individual child, any difficult youngster today could be matched with a similar one fifty years ago. In that sense there has been little change.

102. A third perennial issue concerns the training of professionals and carers. It took a long time to establish a national training for social workers but the Certificate in Social Work (CQSW) and Certificate in Social Services (CSS) were in place by 1980 and degree and post-graduate courses have followed. The College of Social Work and Social Care Institute for Excellence have opened, both initiatives reflecting a major change from the early years.

103. However, certain problems associated with training endure. Social work is still seen as a poorly paid occupation for women (85% of child care staff are female). The amount and level of training among residential staff remains lower than that for field social workers, as it has done since records began. But it is the turnover as well as the availability of trained staff that present difficulties at the moment, especially in large cities. Some urban councils have staff vacancy rates of 25% and a 20% annual turnover. For carers, training opportunities tend to have lagged behind those available to professionals but most foster parents and adopters now receive some training and support, although the national picture is still patchy.

104. But even if training improves, there is still a problem of whether we can actually legislate for good care. The research by Ian Sinclair and colleagues shows clearly what children want and value in foster and residential homes – fairness, personal concern, respect, commitment, freedom from bullying, likeable staff – but it is difficult to legislate for this or train people to ensure

this happens. If it can be learned, it is more likely to be from the example set by senior colleagues than by a course or manual. Hence the frequent recommendation in inquiry reports for better training is likely to have limited effect[xli]. No matter how subtle are the processes of recruitment, training, matching and resourcing, there is always an emotional variable which, if we take children's views seriously, must be incorporated into professional practice to achieve good outcomes. Sinclair argues that matching the professional with the human elements is a major challenge to the provision of foster and residential care.

PART 2
Trends and developments in children's services since 1945

105. In the introduction it was pointed out that another way of looking at developments historically is to identify trends, in this case in child care policy and practice. Obviously, with such a vast topic, the possibilities are enormous so nine of those we consider to be important will be selected.

They are:

i. the differentiation and amalgamation of services

ii. the move of rights from the hands of the state to families and to children

iii. the focus on outcomes rather than processes

iv. the influence of research and international comparisons

v. the rise of pressure groups and the politicisation of child care

vi. the balance among providers between independent for profit, voluntary and state agencies, and the growth of social markets

vii. specialisation within a process of professionalisation of the care task

viii. what to do with chronically neglected infants

ix. the problem of enduring instability

Each will now be discussed in turn.

The differentiation and amalgamation of services

106. It is often assumed that social services that rely on regular interaction between professionals and users (as opposed to, say, social security) develop by increasing sub-divisions into more specialist units. Neil Smelser calls this process 'structural differentiation'[xlii] and one can see how quickly it can happen. For example, compulsory education in England was introduced as late as 1880[xliii] yet within the next thirty years, provision had expanded to include schools for the partially deaf (1906) and mentally handicapped (1913), as well as nursery education for the blind (1918). Similarly, while welfare workers and the NSPCC were the main agents of child protection for many years, there are now dozens of professionals trained in this area – teachers, doctors, police, therapists etc. But it is not always appreciated that change also occurs by amalgamation; the *Children Act* 1948 integrated disparate services and the 1969 Act brought offenders into he care system. The Seebohm Report of 1968 (implemented in 1971) gathered social work under one banner and in 2007 social services and education were merged. Thus, administrative and legal reform involves differentiation in terms of increasing specialisation and

amalgamation of previously disparate groups of workers into a stronger and more coherent professions at different times and, to complicate matters, there may be a trend towards specialisation within a process of growing amalgamation.

The move of rights from the hands of the state to families and to children

107. For many years the father's family was perceived as sacrosanct and it was not until 1889 that a voluntary agency (the NSPCC) could enter a home to rescue a child from abuse. But thereafter, the state increased its power over families demanding education and responsible parenting, imposing penalties and instituting powers to remove children at risk of harm.

108. In the 1970s there was concern that the State's powers were too draconian and the voices of children and families were not being heard. The 1970s saw the emergence of *Who Cares?*, *The Voice of the Child in Care* and NAYPIC (National Association of Young People in Care), along with organisations representing carers and birth family relatives. For example, it was argued that even if a mother was proved to be neglectful, grandparents and older siblings might not be. A charity, the Family Rights Group, emerged in the 1970s, encouraged by a perspective emerging from researchers such as Millham, Triseliotis and Marsh[xliv]. It was successful in achieving the more equal balance of power between state and family, as enshrined in the 1989 Act. But as already discussed, the rights movement did not stop there: children now have to be heard and they have a personal right not to be abused and neglected, as laid out in the 1989 United Nations Convention on the Rights of the Child.

109. In the UK the national and local state now has less power, has to argue its case before a court and can expect its plans to be challenged by the family and child. This has given rise to a curious situation whereby more individuals and families are dependent on the state because of age and unemployment, but they have more rights to protect their interests.

110. The process of taking the child's view into consideration has proved more difficult than expected. Obviously a welfare service must seek to meet the wishes of its clients, but a professional assessment of needs may not tally with the users' wishes. In addition, wishes might not be realistic, feasible and might conflict with those of others. Nevertheless, despite this complexity, the fact is that children's expressed needs and wishes are now integral components of any assessment and action plan and have mandatory force.

The focus on outcomes rather than processes

111. Before 1980, most research in child care was descriptive: it merely charted what happened and offered examples. But early in that decade, studies, such as *Who Needs Care*, *Lost in Care* and *Child Care Now*[xlv], began to measure the outcomes of being in care and the findings were not encouraging. They revealed shocking levels of drift, movement, isolation, delayed development, poor educational attainments and higher than expected mental health and behavioural problems. There were few randomised controlled trials that would

help explain what was causing what and as Sir Michael Rutter, the eminent child and adolescent psychiatrist, explained, it was urgent to move from a focus on risk associations (that is what factors are statistically related to each other) to one on risk processes that looks at what is actually causing what [xlvi].

112. In 1977, the Department of Health and Social Security introduced unit returns from local authorities which were very important in allowing greater interpretation of statistics. In the 1980s it decided to act further by commissioning more outcome studies and introducing a recording method that enable social workers to assess the outcomes of the children for whom they were responsible, the *Looking After Children*[xlvii] materials. But it took a long time for this thinking to penetrate practice because there is no requirement for social workers to be familiar with the latest research; it does not matter if they have not read Rowe and Lambert, they won't get the sack and it won't affect their promotion. This extends to some other professions; indeed, as late as 1996 a senior family court judge was able to opine, "I don't see why judges should be interested in outcomes; if they make a wrong decision it's corrected at the court of appeal". Naturally, the definition and measurement of an outcome is still an academic minefield – whose outcome, at what time and at whose expense? - but estimations of the expected effects of interventions is now a regular part of planning for children in a way that was unthinkable forty years ago and, slowly, processes are becoming the servants of objectives rather than ends in themselves.

The influence of research and international comparisons

113. There is no doubt that the social work literature has become more 'academic' in terms of the influence of research and theory. In the 1960s, there were only two or three empirical studies and basic survey material was scant. As one observer said, "It was possible to read a few books and become a world expert". Since then, there has been an explosion in the number of published studies in books and journals and in the application of their findings: the 1989 Act and the refocusing initiative were heavily influenced by research and there are now seven evidence-based centres linking research, policy and practice in new ways. It may be that research has influenced thinking rather than policy or even less practice, especially in social areas, but academic concepts, like attachment and identity borrowed from psychology, and family links and transitions taken from sociology are common parlance in discussions about children's needs. Similarly, theories about school failure and academic under-achievement inform the current strategies to improve the education of children in care and the new Rees Centre has been opened in Oxford to develop these. The Government, too, plays its part by publishing ever more reliable and useful statistics. Although it would be extravagant to claim that child care is a research-based activity, the existence of organisations like *Making Research Count*, *Research in Practice* and the availability of free websites like *Prevention Action* and *Blueprints* suggest that this is an expanding activity whose influence is growing as the economic situation demands that agencies prove their effectiveness.

114. Much influential research has been undertaken in other countries, especially the US. The complexity of conducting international comparisons, for example trying to see what would happen to the same type of case in different countries, means that it is difficult to draw unequivocal conclusions. Nevertheless, there is growing knowledge about policies and practice elsewhere and several international research organisations, such as EUSARF, IPSCAN and The Fostering Network, exchange information. Also, international travel and EU membership mean that professionals and politicians in the UK are more aware of alternatives, as manifest in the frequent citations of Scandinavian welfare and Singapore education as models for others to follow.

The rise of pressure groups and the politicisation of child care

115. There have been children's charities and philanthropists since Elizabethan times and there was a large expansion in the nineteenth century, many led by the revivalist movement, to cope with the effects of the industrial revolution.

116. However, the 1970s saw something different, a plethora of voluntary organisations acting as pressure groups and often dealing with specific issues: for example, the voice of children, step-parenting or the rights of grand parents, rather than general care and protection. Moreover, these new organisations adopted a different approach: a high political and media profile, with CEOs as national figures and strong political links. At the same time, there was an increase in investigative journalism and in independently conducted inquiries, often chaired by respected public figures, that identified areas for reform and put pressure on governments to respond.

117. Unfortunately, hasty responses often produce procedural changes that do not necessarily address the underlying reason for the failures, and so have limited effect on outcomes for children. Thus, the unintended effects of honourable intentions to improve children's situations can be more bureaucracy and the domination of certain issues over others that are equally important for children's welfare. For example, the focus on the trauma experienced by babies and toddlers entering care following abuse by their families is undoubtedly important but can divert our attention from the fact that in England in 2011/2 42% of care admissions and 56% of those in care at any one time were children over the age on nine with figures of and 12% and 20% for the over 16s.

118. This change means that powerful organisations and individuals increasingly take up particular cases or causes, lobby politicians and seek media publicity. It is noticeable that when a social, issue arises, the TV news contributor is more likely to be from a pressure group, a charity or a journalist than an academic or public servant. But whoever is talking, government ministers are required to answer unsolicited questions on child care and are especially exposed during parliamentary questions and appearances before select committees. Indeed, it is significant that Tony Blair and David Cameron have given their personal backing to plans for more and easier adoption.

The balance between independent for profit, voluntary and state providers and the growth of social markets

119. As mentioned earlier, there has been a considerable shift in the UK in the amount of foster care and residential provision provided by agencies other than the local authority and the growth of quasi-commercial relationships between the purchasers and providers of services. There are currently Government proposals to extend this arrangement to child protection and the rest. The aim has been to raise standards by introducing competition and business-style commercial evaluations. In addition, large sums of money have been made available for projects and competitive bids are invited. In England, these have replaced the annual grants given to the leading child care charities to cover their overheads.

120. While this new arrangement is neither inherently good nor bad, it does raise problems for central government seeking to fashion national policies, setting standards and managing inspection. For the agencies, the issues are more practical: developing marketable programmes and recruiting, training and supporting staff and carers. A major question for staff working in these contexts is what is their professional peer group? The US model, where these arrangements are the norm, is to have strong professional organisations that examine, licence, train and monitor practitioners, similar to the Royal Colleges of Medicine in the UK. But social work and residential care staff associations are notoriously weak, as so far are the 'trade associations' for the private providers, and the quality of foster care training is variable. Much is left to the agencies and standards probably vary as, of course, they do across local authorities. Hence, this radical change in provision, which seems to have crept into the system unnoticed, raises a set of problems yet to be resolved. This diversified market is illustrated by the facts that in England today, 36% of foster placements are provided by 250 independent agencies, many of them operating for profit, and 60% of residential ones are in 1,350 private establishments almost all outside the boundaries of the commissioning authorities.

Professional differentiation and professionalisation

121. In the same way that administrative structures differentiate and amalgamate, the professions involved in child care become more specialised but at the same time become increasingly integrated into a single category. Boarding-out officers became child care officers who are now social workers but there are numerous specialisms that carry that label – teams responsible for intake, leaving care, protection, adoption, fostering and residential workers. As might be expected, there is a status hierarchy within the profession in terms of pay and promotion opportunities and residential care is near the bottom with day care, partly because more than others, it employs women on low pay, many working part-time.

122. This raises the question as to whether there is a core of professional knowledge, akin to basic medical or teacher training, that can the be applied universally. But, even if there is, the core of social work training still varies in

different colleges, although perhaps less so than 30 years ago. So while things are improving, we are still not clear whom we want to recruit, what we want them to know, what we want them to do and how we want them to do it.

What to do with chronically abused and neglected infants

123. At various times, particular groups of children have attracted especial interest and been the subject of heated debates, in the 1960s it was infants in institutions, in the 1970s it was adolescents in secure units, both of which have almost been forgotten. Current anxiety surrounds appropriate long-term plans for chronically abused and neglected infants.

124. This concern is partly the result of lowering the thresholds for intervention in child protection but also a reflection of the ways parenting is affected by addictions to alcohol and drugs and of research findings that children kept at home in such circumstances or returned there from care tend to do badly. It also ties in with the 'permanency' perspective and the robust adoption policy in some US states; namely that if a young child cannot be returned home from care within a fixed time, he or she should be adopted.

125. There has long been debate in child care about the boundaries between long-term fostering and adoption for infants and toddlers but this has become particularly salient in the last decade. Some researchers, such as Ward and Farmer[xlviii], are arguing that their findings support early separation and more quick adoptions, others such as Schofield and Thoburn[xlix], highlight the benefits of long-term foster care, especially its ability to hold a fragile family relationship 'in trust' until the child is old enough to understand the situation and decide how he or she wants to deal with it. Whatever the quality of the science, the discussion indicates how underlying ideological issues still underpin child care policies and practices. Some sceptics say that the pressure to increase adoption is simply 'new Puritanism', others say that it is fulfilling social responsibilities for the most vulnerable children while a third group argue that it is demand driven.

126. The debate is also academic. Two psychological concepts, attachment and permanence, are frequently cited in discussions. At a recent Coram seminar, Michael Rutter[l] urged caution, arguing that social workers were applying the concepts too rigidly as if these things were something children either 'had' or 'didn't have'. As a result, professionals get 'stuck' in an either/or situation. Studies of children's development show that children's attachments widen after six months, and as nothing is 'permanent' in their lives, this is the wrong word to use. He suggested 'commitment' as an alternative. He closed by saying that there was a broad consensus among professionals about what these children needed, but that the language used to describe it was not helpful.

The problem of enduring instability

127. One of the problems that has come to dog the British children's services is instability. The lives of children and families 'at risk' are often unstable – serial partnerships, moving house, erratic styles of child care and so on. But

superimposed on this has been the instability of placements, of staff, of administrative arrangements and of funding - all this despite the enthusiasm for permanence. This has raised the question discussed in an influential article, 'Can the corporate state parent?' The conclusion was that it can with difficulty if certain conditions are in place[li]. These include an auspicious context supported by legislation that helps services meet the needs of a very diverse group of children, acceptance of responsibility for supporting them while they are in care and after leaving, better integration between national and local policies based on common values and principles and the delivery of high quality care. But the other side of the coin is that some things do need to be changed – poor staff, inadequate carers, misconceived policies and children's behaviour. The enduring problem has been to strike the best balance between change and continuity, neither sticking to what doesn't work nor introducing change for the sake of it or as a short-term political or professional convenience.

A comparison between the placements of children in care in 1980 and in 2010

128. Two recent articles have compared the situation of children in care in 1980 and 2010. They portray a mixed picture. There have undoubtedly been some dramatic changes in services but other issues persist, despite the attention devoted to solving them.

129. Professor Roy Parker identified the main changes between then and now as: fewer children in care (100,000 to 70,000 in England[lii], although the number has risen from 60,000 in the past ten years), a higher proportion in foster care (35% to 73%), a rise in the number of adoptions from care (1,600 to 3,500) and fall in the proportion of adoptions from care involving children under the age of one (23% to 2%), a decline in the role of voluntary organisations serving children and a virtual disappearance of their care contribution, the disappearance of offending as a reason for admission, an increase in the category 'neglect and abuse' as a reason (21% to 61%), a fall in the number of children on care orders (45,000 to 38,000) but a rise in the proportion that these children form of the total care population (45% to 58%), a rise in the number and proportion of children from ethnic minority groups (figures for 1980 not available, but 27% now classified as 'non-white') and the arrival of new groups, such as asylum seekers. He argues that these changes not only reflect policies and alternative provision, but also changes in the wider society - more divorce, single parent families and youth unemployment - as well as growing inequalities.

130. Parker also notes much of what has been discussed earlier in this paper: the rise of pressure groups and independent inquiries, the growth of research, the emphasis on prevention, the attention paid to children's wishes and feelings, the tightening of administration with time requirements for reviews and decisions, and greater awareness of outcomes and costs.

131. But some things have not changed. Parker notes that we are still unsure about how to tackle poor parenting. Continuities also occur in the ratio of boy to girls in care (55%:45%), the difficulties faced by care leavers and the number

of placement changes while in care. The rates of children in care per 1,000 under 18s in the local population have remained remarkably stable given all the changes in policy and external circumstances as do the differences in rates between local authorities that cannot be fully explained by demographic, social or economic factors.

132. A second study by Bullock and Blower[liii] looked at the placements of 450 children entering care in sequence in England and Wales in 1980 and in 2010. In 2010, a higher proportion of children entering care were under the age of one than in 1980 (21% compared with 11%) and more were admitted because of abuse or neglect (48% compared with 26%). Consequently, fewer came into care because of behaviour difficulties (17% compared with 25%) or family breakdown (35% compared with 49%).

133. But as was the case in Parker's study, not everything has changed for the better. The number of placement changes experienced by children while in care has stayed fairly constant and has only declined over the thirty years in question for those in care for two years (from 77% having at least one move to 62%), with an increase from 19% to 27% in the rate for those in care for less than six months. More concerning was the finding that the percentage of children experiencing more than three moves rose for both groups (from 3% to 9% for the short-stay children and from 9% to 10% for those staying longer).

134. The most startling contrast, however, is the demise of residential care. This echoes what was noted earlier about its diminishing role and the figures for 2010 confirm this point. In England, there are currently 30,000 fewer children in residential care than in 1980. The proportion of first placements in residential settings was 46% in 1980 (21% in observation and assessment centres) compared with only 2% in 2010. The rates for foster care rose from 42% to 75% respectively. Three quarters of all the placements experienced by children in care for two years in 1980 were in residential establishments compared with 2% in 2010.

135. As to the quality of residential care and revelations of abuse, particularly at Haut de la Garenne, set off the Jersey inquiry, two appendices are attached to explain what has happened and why with regard to residential care for children in the England and Wales. What is interesting about Jersey, however, is that in their 1980 report, the social services inspectors form England directed 20 of their 99 recommendations to Haut de la Garenne compared with only 11 on the whole fostering service. They recommended replacing the institution but failing that, radical changes to reception procedures, unit sizes, redefinition of staff roles, in-service training, home comforts, meals prepared in units, leisure facilities, better reviewing of children's progress and the development of alternatives for long-stay children.

Conclusion

136. This paper has charted the main changes in legislation and practice in the UK since 1945. It has done this chronologically by looking at each Act and discussing the reasons for its implementation and the underlying principles

that justified it. It then looked at trends in child care provision and highlighted nine areas where the changes have been significant. In each of these discussions an attempt has been made to compare the situation in Jersey with what has happened in the UK. To illustrate these, a final comparison was made between the children entering care in England 1980 and in 2010.

137. The themes emerging from the various inquiries and development exercises in Jersey have much in common with the UK and subsequent scrutiny suggests that services are moving in the same direction with regard to legislation, guidance and management. However, as outsiders and non-lawyers, we would make the following observations on some of the key objectives, conclusions and recommendations that have regularly featured in inspection reports and policy documents and where there appears to be some need for further development.

Key objectives

The looked- after system is not isolated from the rest of children's services

138. There are attempts to introduce a continuum of services and use care positively to meet a variety of needs and situations. However, most of the background papers are about management with little reference to who does what, to whom, for how long with what effect. Thus, it is difficult to know what services are actually like for those who receive them. We did not get a sense of an overall vision of a comprehensive service and the role that interventions like residential care make within it.

The whole service is needs-led and evidence based

139. The lack of information about children in need and those who come into care, as well as the outcomes of what is done, make it difficult to comment. The management plans are clear but have to be related more closely to outcome evidence to provide a sense of whether the service is any good. For example, there is no mention of validated programmes and methodologies that might help.

All assessment and decisions should be focused on outcomes

140. As we could not find any detail on individual cases and how decisions have been made, it is not possible to answer this question. It may happen but there does not seem to be much official requirement for it to be done.

Services should form a logical and integrated continuum with a single referral point, a single multi-disciplinary assessment and clear thresholds for the application of each service

141. There is little mention in the documents scrutinised of how services fit together or how children qualify to receive them.

A context should be created that supports an integrated team approach and a proper balance between investigation and help; and between prevention early intervention, treatment and diminished recurrence

142. An integrated team system seems to be developing and there are aspirations for a more balanced approach to children and families, but family support is hardly mentioned as a social work method and examples of prevention and early intervention are scant.

The views of children and families should be ascertained and incorporated into plans and the delivery of services

143. Considerable progress has been made in listening to children, but perhaps less so to families. There are aspirations to incorporate them into the delivery of services but no evidence is provided about whether this has happened.

There should be monitoring or even research to check that the match between needs, services and outcomes is optimal and cost effective.

144. There is a serious deficiency here with little evidence available on what is happening and with what effect, the expressed wish to match needs and services better is welcome but not illustrated in the documents reviewed.

Final comment

145. These observations on Jersey Children's Services Department are inevitably limited and one-sided in that they have been informed by a small amount of information and without knowledge of what services are available and what day-to-day practice is like. Nevertheless, what material has been provided suggests that the Department is moving more closely to the UK pattern and seeking improvements to become more effective. The recent legislation, guidance, inspection reports and strategic plans indicate this. Two lawyers who have recently scrutinised child care law in Jersey reach as similar conclusion in that although progress has been slower than in the UK, progress has been made. Nevertheless, they stress that there is room for improvement with regard to listening to and incorporating children's views, strengthening arrangements for their independent representation in legal proceedings and ensuring that any interventions essential to children's welfare are not denied because of cost[liv]. In her article of 2009, Barbara Corbett writes that since 2005 'child law in Jersey has largely followed the English Children Act 1989. Nevertheless, certain areas have been slower to develop in Jersey but this is now changing with very significant developments in child law having taken place over the last year'.

146. However, the papers we have read are mostly about good management, which is a necessary but not a sufficient condition for change. They are also framed in such general terms that no one could disagree with what is being proposed, hence there are few glaring contradictions or weaknesses and so no accompanying dialogue. It appears that there is a more to be done before the Department becomes 'state-of-the-art'.

147. Finally, we were expecting, given Jersey's location and history, to encounter more French influence. Compared with England, France has a different system of child protection and education and is less hesitant to use residential care[lv]. Also, the philosophy of pedagogy and the holistic approach to child development it encourages are important forces shaping professional practice.

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His research career has involved studies of almost every type of residential establishment for children, such as boarding schools, children's homes, approved schools, secure units and therapeutic communities. His other interests cover child protection, youth offending, community services and family support, as well evaluations of interventions, preventative initiatives and epidemiological surveys of the needs of children and families and the services available to them.

He has given evidence to and participated in many working parties concerned with child welfare, for example the Warner Committee, The Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes (1992) and the Department of Health's Support Force for Children's Residential Care (1995). Many seminars have been convened at Dartington Hall over the years to discuss policy and practice issues in children's services, youth justice and family law.

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A personal note on working in residential care in the second half of the 1950s

With respect to my time working in a boys’ home I can add a few things. I was there for about a year in the second half of the 1950s. It was a local authority home run by the Children’s Department. There were usually about 15-20 boys ranging from eight to 16-17. There were just three live-in staff including me although domestic staff came in on a part-time daily basis. One of the attractions of the post was that it came with rent-free accommodation (a flat on the premises) at a time when we were starting a family (two young children already) and were hard-pressed for money. However, the salary was low.

I was never aware of any major abuse of the boys, either by the master or matron (a married couple out of the old public assistance system) or amongst the boys themselves although the regime was rough and ready. The boys had what today would be called learning difficulties but with other problems superimposed; for instance, partial sightedness, day and night soiling, bed-wetting, illiteracy, hearing problems and so on. Looking back the Home was the last resort for boys whose problems had not been adequately dealt with and whose former placements had failed. There was one black lad (8 year old) but there seemed to be no racial jibes or harassment by the other boys.

Visitors were few and far between. I cannot recall a parent or a social worker visiting but one Home Office inspectors did spend the best part of a day there. I never saw his report but nothing seemed to change thereafter. There was little turnover – pretty well the same boys were there when I left as when I arrived.

Declaration of interest
Neither author has any personal or professional connection with or vested interest in Jersey children’s services or with the Childcare Inquiry.

Neither author is a trained lawyer.

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In order to understand the legal context in Jersey, Evershed solicitors supplied 42 legal documents. The most significant for the task in hand seem to be Children Acts of 1969 and 2002, Children's Homes Regulations 2001, Protection of Children Amendment 2004, Children (Contact in Care) Regulations 2005, Children (Parental Responsibility Agreement) Rules 2005, Children (Placement) Regulations 2005, Children (Secure Accommodation) Order 2005, Children's Rules 2005, Children (Voluntary Homes) Order 2005 and Child Custody (Jurisdiction) Rules and Law 2005.
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APPENDIX 1

This is an edited version of the article: R.Bullock, 'Residential care' in G. Schofield and J. Simmonds (eds.) *Child Placement Handbook: Research, Policy and Practice*, London: BAAF, 2009, pp. 201-19.

RESIDENTIAL CARE

The diminishing use of residential care in the UK

As residential care has been such an important part of child care provision in the UK, the diminishing use of this option over the past 30 years represents a major policy shift. It raises the question of why something that was so highly valued in the past is now so out of fashion. In the 1920s, for example, the Thomas Coram Foundation fostered children when they were young and then moved them to a boarding school out in the country, a practice that continued until the 1950s but which now seems incomprehensible.

Many reasons for the decline can be posited: some are obvious, such as rising costs, staffing difficulties, poor child outcomes and abuse scandals, but others are less clear and reflect things such as increasingly sophisticated knowledge about child development, viable alternatives and the broader developments in social work discussed in Roy Parker's introduction to the Wagner Report (Appendix 2).

Residential establishments vary in their size, regime and role but the term generally covers settings in which children are placed with other children for a least one night with the aim of meeting a welfare need and, hopefully, improving their health and development. Children spend the majority of time outside school or work in this context and there are usually no adult family members present. In addition, the number of children will usually exceed the number of staff on duty at any one time.

In 2013, 12% of the 68,110 children in care in England were living is residential homes (10%), schools (1%) or other types of establishment (1%) but the overall figures can give a misleading picture. Although the proportion of all the looked after children living residentially is 12%, they are mostly adolescents and the proportion for the 10-18 age group will be higher, nearer 20%, compared with around 2% for those aged under 11. The relationship between residential care with other services also needs to be considered. For example, in 2009 there were nearly 3,000 young people under 18 in prison department custody who in former years would have been in residential homes and schools. So, it appeared that the decline in the use of residential care for looked after children had led to increased use of prison custody, suggesting a process of one system offloading cases onto another. But since 2010, the number of entrants to youth custody has also fallen, by as much as 55%, questioning this off-loading hypothesis and warning of the dangers of generalising from circumstances prevailing at one particular tine.

Classifying residential care

There have been several attempts to classify the plethora of provision into discrete categories. One, made by Beedell in 1970, identified at least eleven distinct functions - physical care, safety, control, education, relationships, stability, relief to the wider child care system, shelter, containment, assessment and group work. Another, by Berridge (1985), found that the main functions of the children's homes he studied in the 1980s were aiding reception to care, controlling difficult adolescents, caring for groups of siblings, rehabilitating long-stay children and dealing with the aftermath of placement breakdowns.

The most rigorous classification of British and North American establishments for children is that by the Chapin Hall Center for Children in the University of Chicago. (Chipenda-Dansokho et al., 2003). They identified three dimensions that, independent of one another, appeared to differentiate residential provision most sharply. (Other dimensions were significant but were closely related to the three identified).

They conclude that residential provision can be divided according to: the needs of the children being met; the organisational structure used to make the provision and the extent and nature of parental involvement and autonomy.

A five-fold typology of establishments emerged:

1. Facilities that are primarily focused on providing high quality education and less pre-occupied with students' health and behavioural needs.
2. Facilities that provide an enriched educational experience but also address children's psychological and behavioural needs to meet these ends.
3. Facilities focused on meeting an identified cognitive or educational deficit in children's development. Since such deficits frequently have their origins in family dysfunction and/or are manifest in poor behaviour of the child, the placement demands considerable specialist resources.
4. Facilities for children with a mixture of social, psychological and behavioural needs and who are generally educated in ordinary schools. The placement tends to be short and part of a range of provision focused on several family members, not just the child.
5. Facilities for children with serious psychological needs and behavioural problems that overshadow other developmental goals, including education. Some of these placements are secure.

Using this classification, it is clear from what has been said so far that residential care for looked after children in the UK falls mostly in categories 3-5.

Trends in residential child care

In addition to the considerable decline in the use of residential care for looked after children in the UK over the past 30 years, other trends have been identified within the residential sector. In 1996, Gooch identified these as:

- the replacement of single-sex establishments by ones that are co-educational but which, in practice, are dominated by boys
- the increasing age of residents at entry
- more young people with health problems, behaviour disorders and disabilities
- greater racial and ethnic mix
- larger catchments areas, raising problems for educational continuity and contact with home
- more provision by private agencies
- less specialisation by sector with a resulting mix of needs in each establishment
- assessment by need criteria rather than social role categories, such as disabled or special educational needs
- a more generalist service
- shorter stays
- rising cost
- more concerns about rights and protection; and
- further reductions in the size of units and in the numbers accommodated by the system but a larger proportion of the total places in secure accommodation or other specialist centres.

Naturally, the factors that explain changes in the use of private boarding schools, establishments for children with special educational needs or penal institutions may be different from those that affect child care establishments but in all of these sectors the important point is that viable alternatives have been created, even for persistent offenders and highly disruptive adolescents,

Three perspectives can be usefully applied to residential care to help understand the whole picture: the first looks at its role and function in the overall child care system; the second looks at its effects on children; and the third explores what needs to be done to make it work.

(i) Residential care as part of the wider child care system

Evidence from research in this area (Department of Health, 1998) suggests that residence is used differently for different children. It is a first placement for many adolescents coming into care because of family tensions and difficult behaviour but a later choice for children whose foster care placements have disrupted or who present increasingly severe needs, often associated with earlier trauma and abuse. Thus, residential care plays a different role in different areas of a child's life at different times.

These studies reveal two seeming contrasts. The first is that the majority of young people in residence are difficult adolescents in terms of their challenging

behaviour at home, school and in the community. The second is that only a small proportion of all looked after adolescents who display challenging behaviour are placed residentially.

When the needs of the resident children are scrutinised, it is clear that the main reason for choosing residential care nowadays is to control or improve difficult or disturbed behaviour and that most of the other functions suggested by Beedell and Berridge, such as aiding admissions or keeping siblings together, no longer apply. However, these difficulties do not occur in isolation and affect other areas of children's lives, such as poor peer relationships or suspicion of professionals, and may be associated with special educational needs, making the residential task wider than just ensuring control.

Compared with other looked after children, however, the aforementioned studies found that the harm inflicted by parents on the children placed residentially is, with some notable exceptions, less of an issue than in foster care and when it has occurred tends to be emotional and sexual rather than physical. Levels of neglect are also lower and in some cases it was parents at the end of their tether who first approached Children's Services. However, other family difficulties prevail, for example many young people will come from disrupted and reconstituted families and parents with a chronic mental health problem.

Out of area placements

One issue facing professionals placing children residentially is whether to use the local authority's own facilities or purchase places from voluntary or independent providers. This latter group are know as 'out of area' placements, which is a misleading term because purchased placements can often be local. It is more accurate to perceive them as externally purchased. As these add an extra cost to budgets, they are a highly visible item of expenditure and thus subject to wide scrutiny.

A study of 'out of area' placements (Bullock, 2009) found that they are used for four different groups of looked after children, namely: children presenting severe and complex behavioural problems which have exhausted in-house services; children displaying behavioural difficulties and who are at continuing risk of harm; children in need of specialist therapy, especially for sexual abuse; and disabled children whose needs cannot be met locally. Moreover, they are much more used for boys and girls (although the ratio differs across the four groups).

The benefits of external placements have to be balanced against the secondary problems they create for children and families and the risk of being 'out of sight, out of mind'. Many external placements are a long way from the child's home their contact with their birth relatives is infrequent. Often, there are no clear plans for the future other than to stay put. Naturally, as the young people are mostly adolescents, they often form new friendships and emotional relationships in their new area, making return home difficult. While this experience is common

for students going to college at 18, there is a danger that a changing perception of 'home area' will affect looked after young people at an earlier age, without the supports and status that student life brings.

(ii) Effects of residential care

A good care plan for a child should specify expectations about what a residential placement is likely to achieve. But as the young people being admitted are often unsettled and distressed, because of turbulence at home or disruption to foster care, some initial expectations might have to be pragmatic, such as to provide safety and stability. The aims of the residential sojourn will, therefore, be a mixture of immediate benefits and, hopefully, improvement in the child's long-term situation.

Because of this complexity, it is difficult to identify any general effects of residential care as the intervention covers such a wide range of approaches and the evidence that would be necessary to show this, namely a set of randomised controlled trials, is scant. Nevertheless, claims are made in the literature but these are often based on case studies and tend to generalise from one type of provision or particular group of children to the whole child care field. Moreover, there is a further danger of attributing to residential care defects of the care system as a whole.

To clarify the situation, it is useful to differentiate 'procedural' from 'treatment' approaches (Clough et al., 2006). The first stresses good child care practice at the expense of aims and so focuses on making the establishments nice places to live. While this provision does not offer specialist therapy and, as had been shown, control is often the overriding concern, it should nevertheless provide an auspicious context for the work required to meet children's needs, such as improving their behaviour and family relationships, encouraging positive peer interaction and boosting self-esteem.

Second, are 'treatment' approaches, for example those based on special education, behaviour modification or psycho-social models, that fashion regimes and structures to 'treat' assessed problems, such as attachment, conduct and emotional disorders, anti-social behaviour and learning difficulties. While therapies will differ for individual children, the important feature is that the whole regime is conducive to their application and is staffed and structured to that end.

Many other opportunities are offered by residential care, for instance the use of residential groups for therapeutic work, rehabilitative work with children rejected by their families and, of course, the imposition of control, such as for those in secure units.

So what might be expected from a residential experience? Traditionally, it has been suggested, but it has to be said without evidence that attains the status of a clinical trial, that residential care can offer several benefits. These are: to provide

stability and a stimulating environment, to widen cultural and educational horizons, to create a framework for emotionally secure relationships with adults and to provide a setting for intensive therapeutic work. But these gains have to be set against difficulties of providing unconditional love, constraints on children's emotional development, poor staff continuity and marginalisation of children's families and other welfare services. While much is known about the dangers of placing young children in residential care and the neurological and emotional damage it can inflict, much less is known about the effects of such placements on the development of older children.

But two outcomes are more certain, namely that residential care can have a profound effect, for good or bad, on children while they are there and that regimes based on child welfare principles achieve better results than those that do not. Numerous studies have compared changes in the lives of children placed in different types of establishment and found that the incidence of such things as running away and of violent behaviour varies and that these contrasts are not explained by young people's background characteristics, although it is usually unclear whether similar gains would have been made without residential placement. The problem is, however, that benefits rarely carry over or are much reduced after leaving and the long-term effects of residential care have proved difficult to identify. Nevertheless, while there is much less difference in young people's difficult behaviour after leaving, the pattern of good and bad homes is usually maintained, whatever the type of establishment, suggesting that the influence on young people's potentially damaging behaviour while they are resident is mirrored by a smaller but still significant effect on behaviour after departure (Sinclair and Gibbs, 1996).

While long-term outcomes are easy to describe, they are more difficult to explain. For example, follow-up research suggests that some children who are challenging and unsettled while in residential care do quite well in the longer term - some acting out girls for example - while others who are more quiescent, such as withdrawn institutionalised boys, generally fare badly, drifting into homelessness and recidivism (Bullock et al., 1998). Whether this is due to the long-term nature of the children's problems or the differential impact of a residential experience, it is hard to say.

Given these uncertainties, any conclusions about the benefits of residential care will be contentious but some establishments claim success in overcoming its alleged weaknesses (Rose, 1990, 1997; Ward et al., 2003). This occurs, for example, in response to the criticism of failing to provide unconditional love. Follow-up studies of leavers from long-stay residential treatment units, particularly therapeutic communities and those which provide for learning-disabled adults, indicate a model of 'quasi-institutional adoption' and although only a minority of leavers receive such enduring support, the long-term outcomes for those who do are encouraging (Little & Kelly, 1995; Bullock et al., 1998). However, critics argue that the numbers of children benefiting is probably smaller than claimed and the high costs of such provision are making this option increasingly unrealistic.

Of the various studies of residential care undertaken, Whitaker and colleagues (1998) are the most optimistic about residential care. They conclude that, although there is no list of circumstances under which residential care should be a preferred option, there are occasions when it can be helpful. These are:

- when there is a deficit in attachment forming capacity and a young person can benefit from having available a range of carers;
- when a young person has a history of having abused other children;
- when a young person feels threatened by the prospect of living in a family or needs respite from it;
- when multiple potential adult attachment figures might forestall a young person from emotionally abandoning his or her own parents;
- when the emotional load of caring for a very disturbed or chaotic young person is best distributed among a number of carers; and
- when the young person prefers residential care to any form of family care, and would sabotage this if it were provided.

In a later research review, however, Rushton and Minnis (2002) are less convinced. They express concern that staff in residential homes have no training or contact with child and adolescent mental health services (CAMHS) to help them deal with the problems they face. They suggest that all of the treatments offered to troubled and troublesome teenagers can be delivered in foster care where there is less likelihood of bullying, sexual harassment and delinquent cultures. In contrast to Whitaker, they argue that when children have attachment difficulties, therapeutic foster care seems preferable. But given the control difficulties that some young people present, there is probably a need for a small number of high quality residential establishments for children who cannot be accommodated any other way or for whom there is a policy to keep them out of prison.

The children's views provide a useful indication. Much of the discussion in children's accounts of being looked after focuses on relationships, whether between children and staff or among peers and how important and empowered they feel when their views are taken seriously. A novel attempt to combine the child's view of residential life with statistical research evidence on outcomes is found in *A Life without Problems: The Achievements of a Therapeutic Community* (Little and Kelly, 1995) in which the findings are informed by a juxtaposition of quantitative evidence on children's care careers and qualitative material from a teenage girl's diary.

When asked for their views, children are often complimentary about residential care, at least in its modern version, stressing the care and attention they receive. But, again, there is a problem of interpretation in that Sinclair and colleagues (1998) found that life after a favourable experience was often wretched and its poor quality meant that there was only a weak correlation between a good residential experience and happiness thereafter. Some young people find the contrast between the caring home and the uncaring community too much to handle. Obviously, a child needs to feel safe and be happy while looked after, but this must not be at the expense of longer-term misery and isolation.

(iii) Residential establishments as organisations

When the child's needs have been assessed and a residential placement identified, how can professionals decide whether the establishment is any good?

When looking at residential establishments for children, the immediate reference points are the surface features, such as the style of leadership, the fabric and resources. Judgements about quality are often reached from immediate experiences, initial conversations with staff or the visible responses of the children. It is easy to assume that the most important aspects are either the people or the regime and that, if these elements are right, all will be well. But a stream of research into this area has revealed a more complicated situation.

Certainly, individuals, whether an efficient manager or an unruly adolescent, are important in affecting what happens in a home or school but they are not enough to explain everything. Successful managers in one context often fail elsewhere and establishments vary in their capability to help young people (Hicks et al., 2003). Some features that common sense might associate with a good home have been found to be relatively insignificant - the quality of buildings, the proportion of trained staff, the characteristics of the children, for example, are not sufficient *on their own* to produce good results.

What aspects of residential settings have been found to be associated with good quality care and optimal outcomes for children and families?

While residential homes have many aspects that can be easily differentiated, such as buildings or staff roles, there is something more than the sum of the parts that seems to be important in determining what happens therein. Many writers have used terms such as 'culture' or 'ethos' to describe this. It is precisely these feelings and messages that a visitor picks up. They may be long standing, such as when there is a traditional way of doing things or may be a product of stress or boredom. These cultures have been shown directly to affect the behaviour of children and staff, not just in terms of conformity or deviance but also in shaping attitudes. However, as the precise nature and direction of the association has been difficult to determine, the principal message for managers was to ensure that cultures did not cohere in a negative and destructive way. But, even then, homes seemingly well planned from the start have failed to succeed.

Several studies have help us understand better how residential establishments work: *Working in Children's Homes: Challenges and Complexities* (Whitaker et al, 1998); *Children's Homes: A Study in Diversity* (Sinclair and Gibbs, 1998) and *Making Residential Care Work: Structure and Culture in Children's Homes* (Brown et al, 1998) The first takes a relatively unusual starting point of the experiences of staff; the second analyses the factors that predict optimal outcomes and the third looks at the relationship between staff and child cultures to unravel precisely what causes what.

All three studies reach similar conclusions although they express them in different ways. In general terms there has to be a complementary relationship

between: the needs and wishes of the children, what the home or school tries to do and how it is resourced and structured to do this, a belief among staff that the aims are feasible and that they have been given sufficient responsibility to undertake the work. Moreover, all of these have to be pursued in a child welfare context and a wider ethos of corporate parenting in the responsible agencies.

Naturally, many factors generate these conditions and among those identified are: the rate of turnover; admissions policy; mix of children with regard to needs; ethnicity and gender. There are also indications of what leads to good outcomes. Sinclair and Gibbs (1998), for example, concluded that homes did best if they were small; the head of the home felt that his or her role was clear, mutually compatible, not disturbed by reorganisation and that he or she had autonomy; and, that staff agreed on how the home should be run. Other researchers have emphasised the quality of staff-child relationships, stressing listening, informality, availability, sensitivity, being informed, respect and an ability to offer practical help.

Although the importance of individual factors, for example the size of home, might be argued, there is little doubt that if these conditions are in place, the establishments are not only likely to achieve better outcomes but are also more likely to satisfy children's wishes. Sinclair and colleagues found that young people judged homes according to whether they wanted to be there, whether there was a purpose to their stay, whether they moved on at the right time and the quality of life on leaving. Even though a third of them wanted to be somewhere else, they appreciated homes if they were not bullied, sexually harassed or led into trouble, if staff listened, the regime was benign and the other children friendly and if they showed some tangible improvement, such as in education. Most wanted contact with their families but not necessarily to live with them. Individual misery was associated with sexual harassment, bullying, missing family and friends, poor relations with other residents and lack of success in esteemed roles such as sport.

Conclusions

The studies discussed all emphasise that when children are looked after, there is a danger that deficiencies in the care placements will exacerbate the deprivation and harm that necessitated the initial separation from family. Residential care is no exception. A child doing badly in residential care needs a good quality intervention, not transfer to another poor quality home. System neglect, whereby the needs of children remain unmet, is less obvious than physical or sexual abuse but is no less dangerous. So, what message do researchers offer to those placing children?

Three general messages are indicated. They are:

- There is limited value in looking at residential establishments in isolation. There might be organisational changes to improve situations, such as better record keeping or more effective communication, but these are unlikely to be sufficient to guarantee high standards;

- there has to be an initial understanding of the needs of the children being looked after. This is not always the case, resulting in opinionated generalisations about children's situations and limited action in areas such as health, education and work with families;

- there has to be awareness that residence is only one of several means of meeting the child's needs and an understanding of how it contributes to meeting the needs of a particular child. These two points should be reflected in the services provided and the care plans fashioned.

In addition, some shifts in thinking would be helpful. For service managers, two mind-sets need to be challenged. First, is the tendency to view residential care as a last resort, as something to fall back on when other interventions fail. The second is to provide residential facilities but then put in place services to keep children out of it. Residence is a method of social care and should be used as such, so arguments 'for' or 'against' it are absurd. In some instances it is needed, in others it is irrelevant.

For practitioners, two aspects of matching interventions to children's needs are important. First is what actually happens in residential care and, second, what a residential experience adds to a child's welfare. There are few interventions specific to particular care settings, although opportunities may be greater in some contexts than others. In this respect residential care is no different to foster care or living at home.

For the reasons explained, specific effects of residence are claimed but not proven but it does seem to be helpful in two situations. The first is for adolescents whose challenging behaviour at home, school and in the community requires placement in a supportive but emotionally undemanding setting, staffed by experienced people. This should encourage continuities in the young person's social life, education and employment and those family and peer relationships that he or she wishes to pursue. Stays should be short and there should a clear exit strategy. The difference between this and a foster home is in the roles of staff, the relationship demands made on the young person, the availability of a peer group and the capacity of the establishment to contain the effects of difficult behaviour and prevent status deterioration. From the point of view of the child's living experience, however, it may not be obviously different from a large foster family.

The second is when there is a need for specialised therapy or treatment, either within the residential establishment or outside it. In these situations, what matters is that style and ethos of the residential setting support what is required by the treatment. For those seeking such placements, the aspects to consider are: the value of the group of residents; the availability of a number of adults and freedom to choose with whom to make relationships; the undemanding emotional nature of the ambience that gives the young person choice and power; an environment that ensures safety, supervision and control and an active stimulating programme. It might be possible to achieve equally good outcomes in

foster care or with support at home, but for some individuals and in some situations it is not.

The responsibility of those managing residential establishments is to ensure that the 'culture' of the unit is positive. Congregating difficult adolescents creates potential problems and the studies of children's homes have all found places dominated by crime, bullying, drugs and prostitution, and staff who turned a blind eye to such behaviour.

Finally, service managers cannot ignore the wider population of children in need as the amount and type of residential provision will be affected by broader policies, such sending young offenders to prison and willingness to accommodate troubled and troublesome teenagers. Good quality residential care can exist within a system of poor adolescent services, and may unwittingly support it.

The future of residential care in the United Kingdom

The future thrust in children's services in the United Kingdom will be on prevention and early intervention and not residential care. Initiatives are being introduced to identify children at risk and act accordingly, preferably by providing help in family and home community settings. For those in out of home care, there is also a move to speedier permanency. This most certainly means quicker family reunions for some and more adoptions for younger children unable to return home. Neither is there a group of young children who need to be taken out of residential care, as is the case in some other developed countries (Browne et al., 2005)

In such a context, residential care is likely to continue to play a small but significant role in children's services. But, because of expense, alleged ineffectiveness and difficulties of staffing, it will continually be replaced by foster care that is increasingly able to provide for children who are difficult to place. However, there will be a limit to what is possible, and there is a risk that difficult cases will be diverted more readily to the criminal justice system or turned away altogether rather than offered a residential placement. There will almost certainly be a growth in private residential facilities as local authorities find it difficult to make their own provision. Similarly, some specialist fostering arrangements may become more quasi-residential groups than traditional family settings, thus breaking down traditional boundaries between different types of service.

The main criteria for entry to residential care will remain difficult behaviour, especially dangers to self and others and a need for specialised services. There is no reason to believe that the size of this population will decline as psychological disturbance among juveniles is growing in the United Kingdom (Maughan, 2005); so new provision may struggle to maintain the status quo. But financial constraints will mean little growth in expensive psycho-therapeutic facilities. If there are to be regime changes, they are likely to emphasise flexibility with other

living arrangements, education, social skills and employment. Neither should the pragmatic constraints on reducing residential provision be underestimated. it may prove just as difficult to recruit specialist foster carers as it is residential workers.

The starting point of any planning, whether for systems or for individual children, is the needs of the young person and what is deemed necessary to meet them. The first question to be asked, therefore, is what does the young person and his or her family need? Does he or she need residential care, and if so what for, of what type, for how long and with what else? For those qualifying, the next question is what regime and treatment approaches are shown by research to be the most effective for meeting those needs? To answer this properly, we need a yet undeveloped validated taxonomy of need and robust evidence on the outcomes of interventions for children with similar needs. However, the research that has been discussed offers some pointers. While considerable effort may be needed to implement its suggestions, the benefits of providing residential care as part of a comprehensive service for children in need should be apparent in improved outcomes for children and enhanced job satisfaction among staff.

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APPENDIX 2

The Wagner Report 1988: *Residential Care: A Positive Choice*

Volume: I. Sinclair (ed.) *Residential Care: The Research Reviewed*

Chapter: *Children* by R.A. Parker pp. 57-124

As this had to be scanned from a book, this is attached to this report as a separate pdf file. The layout and print size might may need reformatting.

APPENDIX 3

The legislation, guidance, rules and regulations relevant to the Jersey Child Care Inquiry.

APPENDIX 7

Legislation Study by Richard Whitehead

Witness Name: Richard Whitehead
Statement No: First
Exhibits: RW1-RW87
Dated: 1st September 2014

THE INDEPENDENT JERSEY CARE INQUIRY

WITNESS STATEMENT OF RICHARD WHITEHEAD

I, **Richard William Whitehead**, of the Law Officers' Department, Morier House, St Helier, Jersey JE1 1DD will say as follows -

PART 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

1. I am a Principal Legal Adviser in the Law Officers' Department and the Director of the Civil Division of the Department, a post I have held since 2009. I am a Barrister at Law in England and Wales. I was called to the Bar by the Honourable Society of the Middle Temple in November 1974. I have lived and worked in Jersey since December 1988, first as an Assistant Law Draftsman in the Law Draftsman's Office, then from February 1994 until January 2000, as a Legal Adviser in the Law Officers' Department and from then up to date as a Principal Legal Adviser.

2. I have been asked to assist the Independent Jersey Care Inquiry with evidence about the history and development of Jersey legislation relating to children and child care, from 1945 to the present day. In order to do this I have searched in the files kept in the Law Officers' Department and in the files kept by the States Greffe and Law Draftsman's Office relating to the various items of legislation.

3. A short description of the different types of legislation in Jersey may be helpful to set the scene.

1.2 Principal or primary legislation

4. **Laws** - are made by the Sates Assembly and sanctioned by Her Majesty in Council and registered in the Royal Court. They are principal or primary legislation and are thus equivalent to an Act of Parliament.

5. **Acts of the UK Parliament** - rarely, Acts may apply to Jersey directly. More commonly, but nowadays only infrequently, Acts may be extended to Jersey by Order in Council under a permissive extent provision. Section 107 of the Children Act 1989 is an example of such a provision, though it has not been used, of course. Extension may be with such modifications as are requisite. Extension of an Act is always done at the request of the Jersey Government. They rank as principal legislation.

1.3 Subordinate or secondary legislation

6. Permanent **Regulations** are made by the States Assembly but do not require Royal sanction. They are made by virtue of an enabling power in a Law (or rarely in an Act applying to Jersey) and they are subordinate or secondary legislation, except when they amend a Law, in which case they count for some purposes at least as principal legislation (see Article 1(1) Human Rights (Jersey) Law 2000). The closest UK parallel to this type of Regulations might be Regulations made in the UK which are subject to the affirmative resolution process in Parliament.

7. **Orders** - are also made under a provision in a Law (or in an Act applying to Jersey) but are made, since 2005, by a Minister, or before the coming into effect of Ministerial government, by a Committee of the States. Orders may be annulled by a resolution of the States (see Article 1, Subordinate Legislation (Jersey) Law 1960).

8. **Triennial Regulations** - are made by the States Assembly under an Order in Council of 1771, may exist for up to three years and may be renewed for successive periods of three years under an Order in Council of 1884, if they relate to purely municipal and administrative matters, do not infringe the Royal Prerogative and are not repugnant to the permanent political or fundamental laws of the Island. They count for some purposes as principal legislation (see Article 1(1) of the Human Rights (Jersey) Law 2000.

9. **Rules of Court** - governing the conduct of proceedings under a Law are made by the Royal Court either under specific enabling power in a Law or under the Royal Court (Jersey) Law 1948.

10. Other forms of legislation applying in Jersey but which are not likely to be relevant to the work of the Inquiry include:

    a. Standing Orders governing proceedings in the States Assembly, prerogative Orders in Council;

    b. Church measures;

    c. Regulations and Orders made by a UK authority, usually a Minister or a body such as OFCOM, under an Act as extended to Jersey by an Order in Council; and

    d. EU legislation within the scope of Article 355(5)(c) of the Lisbon Treaty and Protocol 3 to the UK Act of Accession to the EC Treaty, having direct effect in Jersey.

11. I should also mention, in addition to legislation, and of far greater antiquity in its origins, that the other principal source of Jersey law is the customary law, which is derived from the customary law of the Duchy of Normandy.

PART 2: CHILD CARE LEGISLATION IN FORCE IN 1945

12. The following child care legislation was in force in Jersey in 1945.

2.1 Loi appliquant à cette Île certaines des dispositions de l'Acte de Parlement intitulé "Children and Young Person's Act, 1933" (23 Geo. 5, ch 12), confirmé par Ordre de Sa Majesté en Conseil en date du 21 Février 1935 ("the 1935 Loi")

a. The 1935 *Loi* introduced the elements of the UK's Children and Young Person's Act 1933, which related to criminal justice for children and young people and provided the Royal Court with the authority to order young offenders and young people in need of protection to be sent to an "Approved School". A letter from the Attorney General to the President of the Legislation Committee, dated 5th September 1934 shows that the coming into force of the UK Act was the trigger for repealing the "*Loi* (1896) *sur la détention de jeunes enfants* &ca", which the Attorney General said "*should*

be replaced by a new local law the provisions of which should be in harmony with the material provisions of the English law."[1].

b. The 1935 *Loi* also established the age of criminal responsibility at 8 years old (Art. 1), it did not allow anyone less than 17 years old to be sentenced to penal servitude (Art. 2) and prohibited the imposition of the death penalty on anyone under 18 years of age (Art. 3).

c. The 1935 *Loi* set out the conditions under which the Royal Court could send people under 17 to an "Approved School". This included those who had committed an indictable offence and "a person in need of protection" which was defined in Article 8 as a person under 17 years old who had no parents or anyone legally entitled to care for them, or who was neglected by his parents or legal guardians and as a result of keeping bad company was exposed to moral or physical danger or was not under effective control.

d. Boys under 14 were sent to the States run Jersey Home for Boys, or any other Institution ready to receive them, until they were 16 under the 1935 *Loi* whereas girls under 14 were sent until the age of 18 to any Institution ready to receive them. The difference for girls and boys within the 1935 *Loi* was because there was no States run institution for girls when the 1935 *Loi* came into force. Elizabeth House, the institution which was set up to receive girls, was privately run at that time and could not be compelled in law to receive any particular girl.

Amendments

e. *Proposed amendments*: a note found on the file, dated 10th July 1946 and signed by A.K. Tyrer[2] provided a list of suggested amendments to the Children and Young Persons Law 1935, in response to the Public Instruction Committee's wishes to amend the Law "*so as to permit the control of children and young persons in need of care and protection, after they have left the Jersey Home for Boys or a similar institution, and so as to compel any such child or young person if necessary to follow the employment which has been found for him*". The note provides suggestions to address the matter, linking each to similar provisions in the Children and

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[1] Letter dated 5th September 1934 from Attorney General to President of the Legislation Committee **[RW1]**
[2] Note dated 10th July 1946 entitled Suggested Amendments to the Children and Young Persons Law, 1935 **[RW-S1]**

Young Persons Act 1933 and concludes by suggesting that to achieve this *"it would probably be advisable to take the opportunity to enact legislation also on the lines of Parts I and II of the Children and Young Persons Act, 1933, which respectively deal with the prevention of cruelty and exposure to moral and physical danger as far as children and young persons are concerned, and impose restrictions on their employment."* There is no further correspondence on the files to show why these suggestions were not taken forward.

f. *1947*: an amendment was introduced in 1947, to vest in the Public Instruction Committee the right of parental responsibility for anyone placed in, or already in, an institution in Jersey until they reached 18 years old. This also applied to giving consent to marry[3].

g. *Unsuccessful amendments*: In January 1952 the Elizabeth House Committee proposed that the Loi should be amended to provide that the Royal Court could send female persons in need of care and protection to Elizabeth House as an alternative to sending them to an approved school[4]. Records of minutes, acts and correspondence of the Public Instruction Committee, the Greffier of the States, the Attorney-General and the Education Committee, show that this proposal was considered in some depth during the period 1952 – 1956[5]. During this time a further proposal was added to amend the Loi to empower the Royal Court to order a child to remain in an institution in the Island up to the age of 21 instead of 18. Ultimately, both proposed amendments were rescinded on the advice of the Attorney General who felt that the proposals would not receive Royal Assent[6].

h. *1957*: an amendment was introduced to change the contribution from the parents or guardian of a person, ordered by the Royal Court to be sent to the Jersey Home for Boys or a similar institution, from a fixed rate of 23

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[3] Letter dated 24th October 1946 from Law Draftsman to Deputy Le Quesne, President of Public Instruction Committee **[RW-S2]**

[4] Act of Elizabeth House Committee (11th Meeting) dated 11th January 1952 **[RW-S3]**

[5] Act of Public Instruction Committee meeting dated 22nd January 1952; Letter dated 29th January 1952 to Law Officers of the Crown from Greffier of the States; Act of Elizabeth House Committee (14th Meeting) dated 8th April 1952; Minutes of Elizabeth House Committee (36th Meeting) dated 12th November 1954; Letter dated 11.2.55 with comments that AG agrees; Act of Elizabeth House Committee (40th Meeting) dated 11th February 1955; Minute of Elizabeth House Committee (41st Meeting) dated 18th March 1955; Act of Education Committee (102nd Meeting) dated 22nd March 1955; Act of Elizabeth House Committee (42nd Meeting) dated 15t April 1955; Act of Education Committee (104th Meeting) dated 3rd May 1955; **[RW-S4]**

[6] Act of Education Committee (125th Meeting) dated 6th March 1956; Act of Elizabeth House Committee (56th Meeting) dated 20th April 1956 **[RW-S5]**

shillings a week so as to allow the Court complete discretion as to the amount of the contribution which it might require according to the means of the parents or guardians as the case might be[7].

2.3 Brig-y-Don Children's Convalescent and Holiday Home Incorporation Law 1939

a. This Law, recognising the value of the Brig-y-Don home in providing respite care for children who were convalescing after an illness, physically weak and requiring a period of treatment in the open air or suffering from a curable, non-contagious disease, incorporated the "*Brig-y-Don Children's Convalescent and Holiday Home*" enabling it to act as a business.

2.4 Loi (1939) autorisant le transfert au Public de cette Île des immeubles appartenant à L'Asile dit: "The Jersey Female Orphans' Home"

a. This institution was located in the Parish of Grouville. The purpose of this *Loi*, was to empower the Trustees of the Jersey Female Orphans' Home to cede the "real property" belonging to that institution to the States of Jersey, free of all the conditions attached to it, with the exception of the condition that "*the Institution shall for all times be made use of solely as a Refuge or School ("*Asile ou maison d'Éducation*") for poor children of the female sex who are orphans, or who have been abandoned by their parents.*".

b. Until this point, the Jersey Female Orphans' Home had survived on donations from the public, contributions from the Parishes for girls in its care and occasional grants from the States of Jersey. The facilities had become run down and were described by the Attorney General and Solicitor General in their letter to the Lieutenant Governor, dated 3rd June 1939[8], as "*neither adequate nor satisfactory*" and required an investment of £17,000 to bring it up to the standard of the Jersey Home for Boys, which would not be possible without significant public investment. Since the enactment of the *Loi appliquant à cette Île certaines des dispositions de l'Acte de Parlement intitulé* "Children and Young Person's Act, 1933" the Jersey Female Orphans' Home had gained a new importance and semi-official status as an "Approved School" and this *Loi* aimed to formalise that status "*to ensure that young girls will in the future receive the same high degree of*

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[7] Act of Prison Board dated 7th August 1957 **[RW-S6]**
[8] Letter dated 3rd June 1939 from Attorney General to Lieutenant Governor (ref 39/12) **[RW2]**

comfort and of advantage as is now, and has been for many years, received by the boys at the Jersey Home for Boys"[9].

2.5 Loi concernant les témoignages d'enfants dans les poursuites criminelles 1940

a. This *Loi* enabled the unsworn evidence of a child to be received in criminal proceedings, if the child was of sufficient intelligence to give evidence and understood the duty to tell the truth. However, if the child was a witness for the prosecution, confirmation (corroboration) by another witness was needed in order to convict the accused.

2.6 Loi sur la Protection de l'Enfance 1940

a. This *Loi* had an unusual, perhaps unique, procedural history. It was adopted by the States on 20th February 1940 and sanctioned by the Privy Council on 26th June 1940 but could not be registered in the Royal Court (a process which all Jersey principal legislation is normally required to go through before it can be brought into force) until 9th June 1945. This was because Jersey was occupied by German forces from 1st July 1940 until May 9th 1945. The *Loi* was brought in to protect children who were placed in private foster care in return for a fee. The *Loi* made any such child the object of a supervision order to protect their life and health by requiring that any person taking in a child for money obtained authorisation from the Public Health Committee. The *Loi* set out the conditions that the foster parent must meet to receive such authorisation, including: a certificate of good living and morals from the Connétable of the parish in which the foster mother lived; a certificate of aptitude from a registered doctor; and, a health certificate from a health inspector. The *Loi* also placed a requirement on both the parent(s) and the foster carer to communicate any changes in care to the Medical Inspector.

b. Examination of files relating to the *Loi* reveals the following issues of possible relevance for this Inquiry -

b (i) In a letter dated 14th October 1950 to the Attorney General, the Medical Officer of Health ("MoH")[10] proposed a draft regulation to

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[9] Ibid.

[10] Letter dated October 14th 1950 from Medical Officer of Health to Attorney General **[RW3]**

be made under the *Loi* which would enable the Public Health Committee to pay for the upkeep of foster children and to receive part or all of the payment from parents or guardians. The Attorney General responded by letter dated 2nd November 1950[11], that although he agreed with the arrangements proposed within the draft Regulations, there were no *vires* in the *Loi* for making them and the only basis for making provision on the lines of the proposed Regulations was by amending the Law itself.

b (ii) In a letter from the MoH to the Solicitor General dated 29th August 1951[12], the MoH explained tension between the MoH and the Parish leading to dissatisfaction with the way in which the provisions of this Law were being executed. He sought advice from the Solicitor General about who had overall administrative control, as he felt that the Public Health Committee was responsible in law. A file note dated 6th September 1951[13] recorded that in conversation with the MoH the Solicitor General had agreed with the MoH's stated legal position and had recommended that the MoH try to "*straighten out the matter with the Constable as a first step*" and offered to "*arrange a conference*" between himself and the parties if this was not successful. No further correspondence on this matter is available in the files.

b (iii) In a letter dated 5th February 1954[14], the MoH raised further concerns that children boarded out or otherwise under the care of the States came under the supervision of three separate bodies (the Public Health Committee, the Public Instruction Committee and the Poor Law Commission and the Constable - these last two being regarded as one body) with no clear overall control for one of those bodies. He felt that the "*multiplicity of control leads at times to children being pushed around like cattle to their mental and physical detriment*". He explained that he had tried to form a committee at the administrative level but that it had failed. He sought confirmation from the Attorney General that power be vested in one

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[11] Letter dated 2nd November 1950 from Attorney General to Medical Officer of Health **[RW4]**
[12] Letter dated 29th August 1951 from the MoH to the Solicitor General **[RW5]**
[13] File note dated 6th September 1951 **[RW6]**
[14] Letter dated 5th February 1954 from Medical Officer of Health to Attorney General **[RW7]**

committee, namely the Public Health Committee, who would be ultimately responsible "*if a foster child died under conditions which on investigation by the Court were unsatisfactory*" so that he could use it to "*strengthen his hand*" when calling the other organisations together to give the proposed administrative committee their official blessing. There is no evidence on the files that the death of a child in a private fostering had prompted the MoH's concerns.

b (iv) It is unclear from the files, whether he received the confirmation he sought.

c. The *Loi* was repealed in 1969, when the Children (Jersey) Law 1969 came into force.

PART 3: CHILD CARE LEGISLATION INTRODUCED SINCE 1945

3.1 1945 - 1968

3.1.1 Adoption Laws

(i) Adoption of Children (Jersey) Law 1947 (and amendments)

a. The Adoption of Children (Jersey) Law 1947 (originally referred to as the draft Adoption of Infants (Jersey) Law 19.) was based on the Adoption of Children Act 1926 (9 Stat.827) as amended by the Adoption of Children (Regulation) Act, 1939 (32 Stat.305) with a few minor amendments to reflect that Jersey did not have any adoption societies[15]. An "infant" is defined in the Law as a person under the age of 20, whereas the 1926 Act defined an "infant" as a person under the age of 21. The difference was "*to bring the proposed Law into line with existing legislation in Jersey*"[16]. Twenty was historically the age of majority under the customary law of Jersey until it was reduced to 18 by the Age of Majority (Jersey) Law 1999, with effect from 1st November 1999.

b. Although there is nothing within the files to indicate this, the timing of its enactment might seem to support anecdotal evidence suggests that the trigger for bringing in this legislation in Jersey at that time was the number of illegitimate births both during and post war. As well as providing some

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[15] Notes on the Draft Adoption of Infants (Jersey) Law 19- **[RW8]**
[16] Notes on Draft Adoption of Infants (Jersey) Law 19- **[RW9]**

legal protection for parents who had taken in orphaned and/or illegitimate children as their own, this Law enabled mothers of illegitimate children to adopt their child with a new husband.

c. In 1957, the Adoption of Children (Amendment) Jersey Law 1957 was introduced to allow the adopted child or adopter to benefit from insurance policies that were taken out in the name of the child by the natural parents.

d. In 1959, a further amendment (Adoption of Children (Amendment No. 2) Jersey Law 1959) was introduced to change the meaning of the word "abroad" to mean outside the British Islands. The amendment of the Jersey Law was triggered by an equivalent amendment of the adoption law in England and Wales, as notified by letter dated 28th June 1957[17] from A.D. Gordon-Brown (Home Office) to the Attorney General. In his response dated 6th August 1957[18] the Attorney General agreed with the proposition and asked to be kept informed as to whether the proposal was adopted in the UK as he noted that a reciprocal change of Jersey's law would be required so the UK would no longer be regarded as "abroad" for the purposes of the Adoption of Children (Jersey) Law 1947. This was duly done[19].

(ii) Adoption (Jersey) Laws 1961-1965

a. The Adoption (Jersey) Law 1961 closely followed the Adoption Act 1958 of England and Wales except for in one important respect. As explained in a letter from the Attorney General to Mr Gordon-Brown, Home Office, dated 5th February 1962[20]. Whereas, under section 16(1) of the Adoption Act 1958, an adopted child lost any right to property to which he might have been or become entitled as the child of his natural parents but acquired instead new rights of property as the child of the adopter, the corresponding Article 15 in the Adoption (Jersey) Law 1961 worked in the opposite way in that an adopted child retained its rights to property to which he may have been or become entitled as the child of his natural parents, but did not acquire any new rights to property as the child of the adopter.

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[17] Letter dated 28th June 1957 from A.D. Gordon-Brown, Home Office to C.S. Harrison, Attorney General **[RW10]**
[18] Letter dated 6th August 1957 from C.S. Harrison to A.D. Gordon-Brown **[RW11]**
[19] Letter dated 26th August 1958 from A.D. Gordon-Brown to R.H. Le Masurier, Solicitor General **[RW12]**
[20] Letter dated 5th February 1952 from Attorney General to A.D. Gordon-Brown, Home Office **[RW13]**

c. Firstly, following dissatisfaction expressed by a number of States Members in relation to the difference in inheritance rights outlined above, the Education Committee quickly brought forward a proposition to reflect the provisions of section 16(1) of the Adoption Act 1958.

d. Secondly, a working group was brought together with representatives from the Island, England and Wales, Scotland, Northern Ireland, Isle of Man and Guernsey to effect changes in the respective laws to accord reciprocal recognition of adoption orders between the separate jurisdictions of the British Isles[21]. Following this the Deputy Bailiff wrote to the President of the Legislation Committee to inform him that the Home Office was preparing legislation to secure reciprocal recognition of adoption orders between the various jurisdictions of the British Isles[22].

e. Subsequent Acts of the Legislation Committee[23] show that this amendment was debated and agreed and both amendments were enacted in the Adoption (Amendment) (Jersey) Law 1965.

3.1.2 Public Instruction Committee Act 1953

a. This executive act[24], which replaced the Public Instruction Committee Act of 4th December 1949[25], whilst not strictly speaking legislation is relevant. It set out the conditions for the reception of children into the care of the Public Instruction Committee. This replacement Act came about on the advice of the Treasurer of the States that there was no legal authority for the Public Instruction Committee to increase the charges for children boarded out with foster parents[26].

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[21] Note of a meeting held at the Home Office (Thames House South) on 15th July to discuss the recognition of adoption orders in the British Isles **[RW14]**

[22] Letter dated 17th September 1963 from Deputy Bailiff to President of the Legislation Committee **[RW15]**

[23] Acts of the Legislation Committee dated 6th December 1963, 4th December 1964 and 15th January 1965 **[RW16]**

[24] Act, dated 17th November, 1953, of the Public Instruction Committee Submitting to the States, for their Information, Conditions for the Reception into Care of the Public Instruction Committee **[RW17]**

[25] Act, dated 3rd December, 1946, relating to the admission of children to, and withdrawal of children from, the Westaway Creche, the Jersey Home for Boys and the Jersey Home for Girls (lodged 18-12-46, adopted 20-01-47) **[RW-S7]**

[26] See Act of Public Instruction Committee (45th Meeting) dated 8th June 1953; Act of Finance Committee dated 17th June 1953; Act of Public Instruction Committee (46th Meeting) dated 23rd June 1953; letter dated 18th July 1953 from States Auditor to President of the Finance Committee; Act of Finance Committee dated 29th July 1953 **[RW18]**

b. A report entitled Children Boarding Out presented at a meeting of the Public Instruction Committee in October 1953[27] stated that "*the boarding out of children as a definite policy of the [Public Instruction] Committee began in 1949 (Act of Committee 4/4/49) when the Institutions were overcrowded.*". Boarding out was considered by the Committee "*as an extension of boarding at one or other of the Institutions. A special amount was included in the Budget and claims have been made on the Constables and others for repayment*". It was only when the Public Instruction Committee decided to increase the fee levied for children boarded out that it became evident that the charging regime needed to be regularised. An Act of the Public Instruction Committee in November 1953 shows that from 1st November 1953 the Poor Law Commission agreed to pay the fees formerly paid by the Public Instruction Committee to foster parents in respect of children chargeable to the Parish of St Helier[28].

c. The Act required applications to take over the care of a child to be made by the Constable or other authority or person responsible for the maintenance of the child (Art. 1(1)) and to be accompanied by a recent certificate of health, signed by a medical practitioner (Art. 1(2)). The Committee could, at its discretion, admit the child to a Children's Home (*i.e.* Westaway Crèche, Jersey Home for Boys or Jersey Home for Girls (Art. 5)) or a private home (Art. 2) and also had the right to refuse to receive a child into its care under certain conditions set out in Art. 3. The Constable or other authority or person responsible for the maintenance of the child in the care of the Committee also had to pay a fee towards the cost of maintenance of the child (Art. 4).

d. In 1955 the name of the Public Instruction Committee was changed to the Education Committee[29] and subsequent amendments were made by Acts of the Education Committee dated 22nd March 1960[30], 4th December 1963[31] and 25th December 1965[32] to increase the level of payments levied.

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[27] Act of Public Instruction Committee (54th Meeting) dated 13th October 1953 with accompanying note entitled "Children Boarded Out" **[RW19]**
[28] Act of Public Instruction Committee (57th Meeting) dated 10th November 1953 **[RW-S8]**
[29] Public Instruction Committee (Change of Name) (Jersey) Act, 1955 **[RW20]**
[30] Act of the Education Committee dated 22nd March 1960 **[RW21]**
[31] Act of the Education Committee dated 4th December 1963 **[RW22]**
[32] Act of the Education Committee dated 28th April 1965 **[RW23]**

3.1.3 Various laws relating to homes

(i) ***Jersey House of Help (Transfer to Public) (Jersey) Law 1960*** - as the name suggests, this Law transferred the property housing the Jersey House of Help to the public.

(ii) ***Haut de la Garenne Act 1960*** – an executive Act of the States rather than legislation, adopting a decision of the Education Committee to change the name of "Jersey Home for Boys" to "Haut de la Garenne". This coincided with the reception of females to the institution after the closure of the Jersey Home for Girls in 1959.

(iii) ***Jersey Female Orphans' Home Law 1961*** - annulled a condition subject to which the Jersey Female Orphans' Home was ceded to the public of the Island and authorised the transfer of the trust funds of this institution to the States. This was to reflect the fact that "*the States have for some time and with considerable success been pursuing the policy of boarding-out orphan children in private homes and of maintaining those who could not be so boarded-out, both boys and girls, in one institution and the institution chosen for that purpose, because much better suited to it, is the one originally provided for boys*"[33].

(iv) ***Westaway Trust (Amendment No. 2) (Jersey) Law 1966*** - as a result of the decision to accommodate all "*poor and abandoned children . . . in the children's home now established in the Island*" thereby rendering the property in which the Westaway Creche was housed redundant for its original purpose, this Law annulled the condition on which the Westaway Creche was transferred to the public of the Island.

3.2 1969 - 2000

3.2.1 Children's Benefits Funds (Jersey) Law 1969

The Law consolidated a number of different funds established by bequests, devises or gifts into one fund to be applied for the benefit of children in the care of the States.

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[33] Letter dated 29th March 1961 from Attorney General and Solicitor General to the Lieutenant Governor **[RW24]**

3.2.2 Children (Jersey) Law 1969 (plus associated Orders and Rules)

This Law was the major piece of legislation bringing together and repealing almost all of the existing child care and welfare legislation in Jersey, with the exception of the Adoption laws.

Provisions of the Law

Part I: Introduction

a. These Articles contained the interpretation provisions and placed the Education Committee under a duty to provide or arrange for the provision of remand centres.

Part II: Employment

a. These Articles contained controls on the employment of young people.

Part III: Children exposed to physical and moral danger

a. Article 9 set out the punishments for inflicting cruelty on persons under 16 years of age.

b. Article 10 gave the Bailiff authority to issue a warrant to a police officer, or officer of the Committee, to search for or remove a child under 17 years of age to a place of safety, if there was cause to believe that the child was being mistreated.

Part IV: Protection of children in relation to judicial proceedings

a. This Part of the Law included provisions relating to judicial proceedings for young offenders (Arts 11-26) and also for judicial proceedings for children and young people "*in need of care, protection or control.*" (Arts 27-28).

b. Article 11 increased the age of criminal responsibility to 10 years of age.

c. Part IV also included ancillary provisions relating to "fit persons" (Arts 29-31) and the return to the family of a person committed to the care of the Committee.

d. Articles 36 - 37 contained special procedures with regard to offences specified in the First Schedule, which included particularly serious offences against a child such as murder, sexual offences, assault and stealing a child.

e. Articles 38- 48 established the Juvenile Court and set out its jurisdiction and powers and the procedures to be followed in the Juvenile Court.

Part V: Protection of Children of Parties to Proceedings for Divorce, Nullity of Marriage or Judicial Separation

a. This Part made provision in relation to the children of persons who are involved in proceedings under the Matrimonial Causes (Jersey) Law 1949 for divorce etc. They included powers for the Matrimonial Division of the Royal Court to make orders committing children to the care of the Education Committee (Art. 53) or to provide for supervision of children by a welfare officer or the Committee (Art. 54).

Part VI: Protection of Foster Children and certain children during school holidays

a. Articles 55 - 67 set out comprehensive measures for ensuring the well-being of foster children. These articles both placed a duty on the Education Committee and also provided it with certain rights to ensure that foster children in Jersey were properly looked after and protected.

Part VII: Nurseries and child-minders

a. Articles 68 - 76 introduced a registration scheme for nurseries and child-minders of children under school age and vested in the Committee the power to impose requirements in connection with registration.

Part VIII: Voluntary homes

a. Articles 77 - 81 defined "voluntary homes" and governed the registration of such homes and the standards required.

Part IX: Duty of Committee to assume care of children

a. Article 82 placed a duty on the Committee to assume care of children who were temporarily or permanently abandoned by their parents. Articles 83 - 87 set out the conditions surrounding a "parental rights order".

Part X: Treatment of children in care of Committee

a. This part of the Law (Arts 88 - 91) relates to the powers and duties of the Committee in relation to children committed to its care.

Part XI: Contributions towards maintenance of children

a. Under this part of the Law (Arts 92 - 97), parents had a duty to pay a financial contribution to the Committee for the care of their child.

Part XII: Escapes from remand centres and approved schools, and from care of fit persons

a. Articles 98 - 100 make it an offence both to escape from a remand centre or approved school and to assist anyone to do so.

General

a. Articles 101 - 109 contain a miscellany of provisions relating to a variety of issues, such as service of notices, determination of age, obstruction of officers.

b. The 1969 Law repealed the following Laws -

   i. Articles 7 and 8 of the "*Loi* (1895) *modifiant le droit criminel*"

   ii. The "*Loi appliquant à cette Ile certaines des dispositions de l'Acte de Parlement*" intitule "Children and Young Persons Act, 1933" (23 Geo. 5, c.12), confirmed by Order of His Majesty in Council of the twenty-first day of February, 1935.

   iii. The "*Loi* (1940) *concernant les témoignages d'enfants dans les poursuites criminelles*"

   iv. The "*Loi* (1940) *sur la Protection de l'Enfance*"

   v. The "*Loi pour investir le Comité d'Instruction Publique des droits paternels à l'égard des personnes qui ont été trouvées par la Cour Royale en besoin de protection et qui ont été envoyées à une Institution dans cette Ile*"

   vi. The Children (Criminal Proceedings) (Jersey) Law 1956 (gave power to the Courts to order parents to pay costs or fines for children under 17 years of age).

   vii. Article 2 and paragraph (2) of Article 8 of the Criminal Justice (Jersey) Law 1957

viii. The "*Loi appliquant à cette Ile certaines des dispositions de l'Acte de Parlement*" *intitule* "Children and Young Persons Act, 1933" (23 Geo. 5, c.12), confirmed by Order of His Majesty in Council of the twentieth day of December, 1957.

Discussion – the genesis of the 1969 Law

a. There appears to have been a general recognition from the late 1950s/early 1960s that new, all-encompassing children's legislation was required.

b. The preamble to a report prepared in early 1960 by the Children's Officer Patricia Thornton, Children's Sub-Committee, entitled "Suggested new children's legislation"[34] starts -

"*The Legislation which I am suggesting that we build our new Children's Legislation on is -*

- *The Children and Young Person Act (Northern Ireland) 1950.*
- *The Children and Young Person Act 1933, and the Jersey* Acte des États *1935 based on the Children and Young Person Act 1933.*
- *The Children Act 1948, and the Boarding-Out of Children Regulations 1955.*
- *The Children Act 1958.*
- *The Matrimonial Proceedings Children's Bill 1958.*
- *The Jersey* Loi *(1940)* sur la protection de l'enfance, *and the Child Welfare Memorandum's Act of the Education Committee No. 3388 dated the 17th November 1953 and No.4128 dated the 22nd March 1960.*"

c. The report included a comprehensive table showing how each of these pieces of legislation was covered in the draft bill.

d. Within the files are further tables[35] setting out the various Acts, Regulations and Laws mentioned above to cross-check how the principles of each have been included within the draft law, which eventually became the Children

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[34] Report by Patricia Thornton of the States of Jersey Education Committee. Children's Sub-Committee, entitled "Suggested new Children's Legislation", dated 30th May 1960 sent to States Greffier. **[RW25]**

[35] Tables (undated) showing cross-referencing of Laws new Children (Jersey) Law 196- **[RW26]**

(Jersey) Law 1969, and annotated copies of the Children Act 1958[36] and the Matrimonial Proceedings (Children) Act, 1958[37], which show how these law were to be adapted to suit Jersey's legislative requirements.

e. A draft copy of the Bill was circulated by the States Greffe for comment in October 1961[38]. In his notes on the proposed Bill, dated 18th January 1962, the Police Magistrate, R.E.B. Voisin, makes the point that in the absence of a local detention centre he "*fail[ed] to see how the law [could] operate*"[39]. Further comments are included in the file, which also appear to be from the Police Magistrate R.E.B Voisin[40], along with notes from the Law Draftsman[41]. These are undated but from their placement in the file would appear to be from later in 1962 or early in 1963. Further comments were received from Mr Voisin again in January 1964[42] and from Mr Newell, also a Police Court Magistrate, in February 1965[43], to which the Attorney General replied in May 1965[44]. This second exchange centred around the local provision of a Detention Centre before the new Children Law came into force in Jersey.

f. Concurrently, the Children and Young Persons Bill was making its way through its various stages to becoming an Act in the UK. Correspondence between Miss Wakeman of the Home Office and the Attorney General highlighted provisions within the Bill of interest to Jersey relating to the arrest in one part of the British Islands of children or young persons escaping in another part[45]. The Children and Young Persons Act 1963 came into force in the UK in October 1963 and February 1964 and was registered and published in Jersey, at the request of the Island authorities, in March 1964. This had the effect of giving notice to Jersey that it had been

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[36] Annotated copy of The Children Act 1958 **[RW27]**
[37] Annotated copy of The Matrimonial Proceedings (Children) Act, 1958 **[RW28]**
[38] Letter dated 7th October 1961 from States Greffe to Miss Thornton, Children's Officer with draft copy of the Children (Jersey) Law 196 . attached. **[RW-S9]**
[39] Notes of R.E.B. Voisin, Police Magistrate on Children (Jersey) Law 196- **[RW29]**
[40] Comments from R.E.B. Voisin, Police Magistrate entitled "Childrens Law" (undated but appear from place in file to be from the end of 1962 / beginning of 1963) **[RW-S10]**
[41] Note on latest draft of Children Law (ref EJP/MM/301) by Law Draftsman (undated but appear from place in file to be from the end of 1962 / beginning of 1963) **[RW-S11]**
[42] Letter dated 4th January 1964 from R.E.B. Voisin to E.J.M. Potter, Law Draftsman **[RW-S12]**
[43] Observations of Mr Newell, Police Court Magistrate on Part IV of Children's Bill (February 1965) **[RW-S13]**
[44] Letter, dated 17th May 1965, with attachment, from Attorney General to M. Newell, Police Court Magistrate **[RW-S14]**
[45] Letters from Miss Wakeham, Home Office to Attorney General dated 2nd October 1962 and 7th June 1963. Letter from Attorney General to Miss Wakeham, Home Office, dated 24th October 1962 **[RW-S15]**

passed in the UK so that although it was not essential to its operation in Jersey 'Her Majesty's subjects' in Jersey were bound by it[46].

g. From its inception to the enactment of the 1969 Law took almost 10 years. It provided, in the widest sense, for the general welfare and well-being of children and young persons in Jersey. One of the reasons for the delay in the second half of the decade when a first draft was sent to the Home Office for comment was because the UK authorities were occupied with a complete overhaul of the UK criminal justice system for young offenders and in turn these changes needed to be reflected in the forthcoming Jersey Children Law. This is because, at that time, Jersey sent all of its young offenders, who were sentenced to detention, to an institution in the UK as there was no local facility.

h. There are a number of references within correspondence between the Attorney General and the Home Office recognising the need to rectify the deficiencies within Jersey's child care legislation at that time. For instance, in 1965 in a letter dated 29th May 1965, the Attorney General provided to D.B. Staines of the Home Office[47], four copies of Jersey's proposed Children (Jersey) Law 196- and requested comments on the draft Bill from the Home Office and other appropriate authorities. This letter opened with the sentence "*The existing law of the Island concerning children and young persons is substantially inadequate, and many important aspects of this subject are not covered by any Insular legislation at all.*". The Attorney General further remarked that "*The Bill re-enacts, with amendments, certain parts of the existing insular enactments governing children and young persons, but many of the provisions of the Bill are new and are based on United Kingdom legislation.*". The Attorney General further noted that the UK government was also undertaking a major reform of the trial and treatment of young offenders and asked to be informed if anything within it would affect Jersey's Bill.

i. The response to this letter was received on 24th September 1965[48] explaining that the delay was due to the general review of UK law and practice being undertaken at that time, which had resulted in Command

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[46] Notification of the registration of The Children and Young Persons Act 1963 in Jersey, dated 26th March 1964 **[RW-S16]**

[47] Letter dated 29th May 1965 from Attorney General to D.B. Staines, Home Office **[RW30]**

[48] Letter dated 24th September 1965 from D.B. Staines, Home Office to Attorney General **[RW31]**

Paper 2742. In light of this, the Home Office asked whether Jersey would "*prefer to consider whether the proposals in the Command Paper are likely to affect your own proposals before [the Children's Department] proceed further with a detailed consideration of your draft.*"

j. The Solicitor General immediately responded on behalf of the Attorney General (in a letter dated 30th September 1965[49]) that the appropriate authorities in Jersey would examine the impact of the proposals in the Command Paper on their Bill. This was duly done and a report from the Education Committee dated 26th January 1966[50] noted that the Education Committee had approved a recommendation from the Attorney General that the Committee should proceed to bring the present draft into force, with the exception of Part IV, which dealt with the establishment of a juvenile court.

k. The following day, 27th January 1966, the Solicitor General wrote again to Mr D.B. Staines at the Home Office[51] requesting that the Children's Department proceed with a detailed consideration of the remainder of the Bill as ". . . *the present state of the law of Jersey governing children is so inadequate for modern needs that the Committee would like to press forward with the Bill, so that at least some of the provisions which are urgently required can be brought into force as soon as possible*".

l. There appears to have been a delay in receiving comments from the Children's Department of the Home Office during 1966. The Attorney General wrote to Mr D.B. Staines in August 1966[52], re-emphasising the inadequacy of Jersey's existing laws on children, stating that "*we are continually having to try to improvise in order to keep in step with modern ideas on child care and treatment*" and requesting observations so that it would be possible to keep to the proposed timetable of introducing the Bill in early 1967. Concerns about the delay were also raised by the Education Committee[53] and shared in a confidential memo by the Attorney General who wrote in a letter to the Director of Education dated 20th September 1966 that he had "*written to, and telephoned, the Home Office several times*

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[49] Letter dated 30th September 1965 from Attorney General to the Home Office **[RW32]**
[50] Act of the Education Committee dated 26th January 1966 **[RW33]**
[51] Letter dated 27th January 1966 from the Attorney General to D.B. Staines, Home Office **[RW34]**
[52] Letter dated 6th August 1966 from Attorney General to D.B. Staines, Home Office **[RW35]**
[53] Minutes of the Children's Sub-Committee of the Education Committee, dated 24th August 1966 **[RW36]**

since the beginning of the year". In his view it was "*pointless to present the Bill to the States until the Home Office comments [had] been received*".[54]

m. Comprehensive comments on the draft Bill were received from the Home Office in November[55] [56] and December 1966[57], resulting in a number of changes to the draft Bill followed by a meeting in January 1967 of the relevant parties in Jersey to discuss the policy implications of the changes suggested by the Home Office. After further consideration, a new and, it was hoped, final draft of the Bill was sent to the Home Office in October 1967[58] for comment. Further comments were provided by the Home Office to the Attorney General in January 1968[59], which necessitated further amendments to the Bill, to which the Attorney General responded later in the same month. [60]

n. In a letter dated 11th July 1968[61] the Home Office wrote to the Attorney General informing him of proposals which were to be implemented in a UK Bill, which would have the effect of abolishing approved schools and replacing them with residential establishments run by local authorities. At that time, all young offenders sentenced in Jersey were sent to approved schools in the UK to serve their sentence as there was no suitable institution in Jersey. The Home Office suggested that "*it might be possible to arrange for [Jersey's] children to be accommodated in the new residential establishments run by [the UK's] local authorities on a repayment basis*" but could not guarantee it until after discussions with the local authorities. The Home Office asked for Jersey's initial views on the matter.

o. Further internal and external correspondence[62] recognised that there would be a need to amend further the draft Jersey Bill as a result of the UK Government's decision to abolish approved schools and concluded that Jersey would wish to have the option of sending young people who up until

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[54] Memo dated 20th September 1966 from Attorney General to Director of Education **[RW37]**
[55] Letter dated 15th November 1966 from Home Office to Attorney General, with accompanying notes **[RW38]**
[56] Letter dated 22nd November 1966 from Home Office to Attorney General, with accompanying notes **[RW39]**
[57] Letter dated 20th December 1966 from Attorney General to the Home Office **[RW40]**
[58] Letter dated 10th October 1967 from Attorney General to Home Office **[RW41]**
[59] Letter dated 10th January 1968 from Home Office to Attorney General **[RW42]**
[60] Letter dated 17th January 1968 from Attorney General to Home Office **[RW43]**
[61] Letter dated 11th July 1968 from Home Office to Attorney General, plus attached Command Paper 3601 entitled "Children in Trouble" **[RW44]**
[62] Correspondence dated August and September 1968 **[RW45]**

that point had been committed to approved schools to the successor institutions. There was further correspondence from the Home Office on this issue during the rest of the year as progress was made on the UK Bill[63]. However, the Jersey authorities decided not to delay the Law further by waiting for the UK Bill in full recognition of the fact that it would be necessary to bring in an amendment, as required, once the UK's Children and Young Persons Bill came into force[64].

p. The States finally adopted the Children (Jersey) Law 1969 on 22nd April 1969, it was sent for Royal Assent on 4th June 1969[65] and it came into force, with the exception of Articles 38-41 and the Second Schedule, on 1st January 1970[66]. The remaining parts of the Law came into force on 1st September 1970[67].

3.2.3 Amendments of the Children (Jersey) Law 1969 ("the principal Law")

(i) Children (Amendment) (Jersey) Law 1972

Provisions of the Law

a. The effect of this amendment was to remove all references to "approved school" and "approved school orders" in the principal Law following the abolition of approved schools in the UK.

b. Other amendments included a change in the wording of Article 10 of the principal Law to enable the Bailiff to issue a warrant to search for and remove a child under the age of 17 on the ground of apprehension as to any future ill-treatment of a child, not just when there was reasonable cause to suspect it was actually happening, as was the case with the principal Law, as enacted.

c. Finally, in the correspondence between the Home Office and the Attorney General there was some discussion about co-ordinating the upper and lower age limits for borstal training. To achieve this, an amendment was introduced to remove the necessity to amend the principal Law by means of

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[63] Letter dated 10th December 1968, from Home Office to Attorney General **[RW46]**
[64] Act of Education Committee dated 25th September 1968 **[RW47]**
[65] Letter dated 4th June 1969 from Solicitor General to Deputy Governor **[RW48]**
[66] Jersey R&O 5300, Children (Jersey) Law, 1969 (Commencement) Act 1969 **[RW49]**
[67] Jersey R&O 5375, Children (Jersey) Law, 1969 (Commencement) (No. 2) (Jersey) Act 1970 **[RW50]**

a "*Projet de Loi*" in the event of ages applicable to Borstal training in the UK being varied (Art. 3).

Discussion

a. The trigger for bringing the 1972 Amendment into force was the need to reflect the far-reaching changes in the treatment of young offenders in the UK, which resulted in the abolition of approved schools and consequently approved school orders[68]. At that time there was no facility in Jersey to deal with young offenders locally and so young persons who the court felt should be removed from their homes were sent, on the issue of an approved school order by the Royal Court, to an approved school in the UK. Following the introduction of the Children and Young Persons Act 1969, approved schools were replaced in England and Wales with community homes under the control of the local authority.

b. This amendment was the subject of considerable discussion and correspondence between the Home Office and the Jersey authorities throughout 1969 and 1970[69] before it came into force. There were two debates running in parallel, firstly on a practical level what form the transitional arrangements would take whilst the new legislation and the new centres were coming into being. Secondly, the type of order that would be needed to ensure that there was provision within the UK's new legislation to enable children from Jersey to be accommodated in the community homes and similarly, the provisions that would be needed within Jersey law to allow that to happen, subject to appropriate safeguards.

c. In the meantime the Home Office drafted the "*Children and Young Persons (Designation of Jersey Order) Order 1972*" to enable the Secretary of State to authorise a local authority in England or Wales to receive into their care any person who was the subject of an order made by a court in Jersey (and

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[68] Letter dated 10th June 1969 from Home Office to Attorney General **[RW51]**

[69] Letters dated: 18th June 1969 from Children's Officer to Attorney General; 19th June 1969 from Senior Probation Officer to Attorney General; 10th July 1969 from Home Office to Attorney General; 14th July 1969 from Lieutenant-Governor to Bailiff; 7th August 1969 from Attorney General to Director of Education; 5th June 1970 from Children's Officer, Jersey to Miss Cooper, Children's Department Inspectorate, Home Office'; 29th June 1970 from Home Office to Children's Officer; 20th July 1970 from Attorney General to Miss Turner; 13th August 1970 from Attorney General to Miss Turner, Home Office; 21st August 1970 from Miss Turner, Home Office to Attorney General; 26th August 1970 from Attorney General to Miss Turner, Home Office; 30th November 1970 from Home Office to Attorney General. **[RW52]**

similar Orders were made in respect of the Isle of Man and other Channel Islands), which was designated for that purpose. The wording of this Order provided some flexibility as to which order was used by the Jersey court.

d. This Order designated a fit person order made by virtue of Article 31 of the principal Law (which enabled a fit person order made by the Royal Court to provide for the committal of the child who is subject to the order to the care of the Education Committee) for the purposes of section 26 of the Children and Young Persons Act 1969. This section enabled the Secretary of State to authorise a local authority in England or Wales to receive into their care any person who is the subject of an order made by a court in Jersey (and the Isle of Man and other Channel Islands), which is designated for this purpose.

e. This Order was not brought into force until agreement was reached about the use of the fit person order and the contents of the Children (Amendment) (Jersey) Law 1972.

f. What later became the Children (Amendment) (Jersey) Law 1972 was first drafted and submitted for Royal Assent on 14th May 1971[70] based on the Education Committee's wish for a separation between fit persons orders, reserved for situations where a young person was to stay in Jersey under the supervision of a "fit person", and "special care orders" for situations where persons were to be sent to the UK to a community home.

g. The Home Office responded on 25th June 1971 with comments from the Children's Department, raising concerns about the use of two different types of orders by the Jersey Court and the Secretary of State, requiring further amendments to be made in relation to provisions for special care orders[71]. The Home Office suggested that the Jersey order should commit the child to the care of the Education Committee who would then have the power or duty to transfer to the care of a local authority in England and Wales.

h. After consultation with the Law Draftsmen[72] and Education Committee the Attorney General responded to the Home Office proposing the use of fit

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[70] Letter dated 14th May 1971 from Attorney General and Solicitor General to Lieutenant Governor of Jersey **[RW53]**

[71] Letter dated 25th June 1971 from M J Hill, Home Office to P L Crill, Attorney General **[RW54]**

[72] Letters dated 7th July 1971 (from Solicitor General to Law Draftsmen) and 13th July 1971 (from Law Draftsmen to Solicitor General) **[RW55]**

person orders for both purposes to overcome the previous difficulties foreseen by the Home Office[73]. This proposal was accepted by the Home Office with the proviso that all children subject to fit person orders would be returned to Jersey on attaining the age of 19. This was because Jersey's fit person orders issued under the principal Law continued until age 20, whereas under the UK's Children and Young Persons Act 1969 there was no provision to accommodate persons of 19 years of age or over.

i. In the meantime, agreement was reached between the UK and Jersey about the transitional arrangements, made under section 26 of the Children and Young Persons Act 1969, which made provision for the transfer to England from Jersey of a person committed to the care of a public authority by an insular court and whom the Secretary of State has authorised a local authority in England to receive into their care. Attempts by Jersey to be included within the jurisdiction of one of the Regional Planning Committees so that children subject to a care order made in Jersey could be received into accommodation provided in a particular area[74] were resisted by the Home Office who felt that this would go beyond Jersey's requirements[75].

j. There was a further delay in bringing the revised Amendment to the States as the Education Department decided to deal with the question of Contribution Orders within the same amendment, which resulted in "*lengthy consultation with the Constables*". In a letter to the Director of Education, dated 1st May 1972, the Attorney General expressed his embarrassment at the delay and reiterated the need to push forward with the amendment in order to regularise the transfer of young offenders to Community Homes in the UK and requested that the Education Committee separate out the two issues in order to expedite the coming into force of the required amendments. The Education Committee accepted this suggestion and the refined amendment, described above, was duly passed by the States on 19th September 1972 and put forward for Royal Assent on 6th November 1972[76]. The Amendment finally came into force on 12th January 1973.

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[73] Letter dated 7th September 1971 from Attorney General to Home Office **[RW56]**
[74] Letter dated 17th May 1971 from Attorney General to Home Office **[RW-S17]**
[75] Letter dated 26th August 1971 from Home Office to Attorney General with attached letter **[RW-S18]**
[76] Letter dated 6th November 2012 from Attorney General to Lieutenant Governor **[RW57]**

3.2.4 Orders and other subordinate legislation made under the Children (Jersey) Law 1969

(i) Children (Boarding Out) (Jersey) Order 1970

a. This Order set out the legislative requirements for boarding out (fostering) children in private households. It required a "visitor", defined in Article 1 as a person carrying out the duties under this Order on behalf of the Education Committee, to oversee the process by checking the suitability of both the accommodation and person responsible for looking after the child. The visitor also had a duty to visit and report from time to time on the welfare, health, conduct and progress of the child (Arts 8-10). The person looking after the child also had to sign a form of undertaking as a suitable person, in relation to the treatment of the child.

(ii) Children (Contribution Orders) (Jersey) Rules 1972

a. Article 93 of the principal Law determined which persons, by whom (parents, legal guardians and children themselves already being paid) and to whom (foster parents and the Education Committee) contributions towards the maintenance of a child were payable. Article 94 of the principal Law provided the power to ensure that these contributions were paid. These rules set out the circumstances under which the Judicial Greffier could make a contribution order under paragraph (2) of Article 94 of the principal Law to compel a contributor to pay and the rules governing the rescission or modification or a contribution order by the contributor.

(iii) Children (Amendment No. 2) (Jersey) Law 1974

a. This Law brought in the right of appeal from the Juvenile Court, which had not been provided for in the principal Law, with the establishment of a Juvenile Appeal Court.

b. The Law also repealed the Articles within the principal law (Arts 44-48) that dealt with the issue of children in court and introduced an amended Part (Part XIIA), which set out the general provisions as to proceedings in court.

(iv) Children (Amendment No. 3) (Jersey) Law 1978

a. This Law further amended the principal Law in relation to the treatment of young offenders. The purpose of the amendment was to take account of the availability of the young offenders' centre for the detention of male

offenders aged 14 to 20 with the replacement of the term "detention centre" and "detention centre order" with "young offenders' centre" and "young offenders' centre order" throughout the principal Law.

b. Further provisions include Article 3 of the Law, which introduced amendments of Article 19 of the principal Law (detention of offenders aged 14 to 20) such that only male offenders could be sent to the young offenders' centre. The Article also provided that the Prison Board would make a report to the court as to whether the young offender would benefit from a period of detention and would further ensure that offenders would not be sentenced if the centre was already full. Article 6 of the Law amended paragraph (5) of Article 22 of the principal Law to provide that the total period of detention at the young offenders' centre would not exceed six months, instead of nine months.

(v) Children (Amendment No. 4) (Jersey) Law 1986

a. This Law amended the principal Law in order to prohibit the pronouncement of a life sentence on a person who appeared to the court to be under 18 years of age when the offence was committed. Instead he would be sentenced to be detained at Her Majesty's pleasure in such a place and under such conditions as the Secretary of State may direct.

(vi) Children (Amendment No. 5) (Jersey) Law 1996

a. This Law brought in amendments to Articles 100A-100C of the principal Law, which dealt with Court proceedings involving children, whether as defendant, victim or witness to raise the age limits in those Articles from up to and including 16 years old to up to and including 17 years old. The effect of this was to bring the maximum ages in line with the provisions of the Criminal Justice (Young Offenders) (Jersey) Law 1994, which set up a Youth Court with the same jurisdiction as the United Kingdom Youth Court, namely to deal with young offenders up to and including 17 years old[77].

b. This Law further amended all of the Articles within the principle Law that dealt with penalties for offences under the principal Law in order to bring

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[77] Letter dated 19th September 1994 from Richard Whitehead, Legal Adviser to Deputy Rumboll, President of the Legislation Committee **[RW58]**

them broadly into line with the equivalent penalties in the UK, as shown in the table attached[78].

3.2.5 Amendments of the Adoption Legislation

a. The period from 1969 - 2000 saw the introduction of three amendments of Jersey's adoption legislation.

(i) Adoption (Amendment No. 2) (Jersey) Rules 1974

a. This Law introduced amendments of the Royal Court rules dealing with adoptions in relation to confidential reports to the Court by a guardian *ad litem*.

(ii) Adoption (Amendment No. 3) (Jersey) Law 1995

a. This law amended the Adoption (Jersey) Law 1961 so as to:

(i) give the Education Committee the power to act as an adoption agency;

(ii) make further provision for the freeing of an infant for adoption; and

(iii) give an adopted person access to their birth records and to relatives, with the establishment of an adoption contact register by the Superintendent Registrar.

(iii) Adoption (Amendment No. 4) (Jersey) Law 1995

a. This Law amended the 1961 Law to allow for the establishment of an Adoption Panel to carry out such powers and duties of the Committee in relation to the Adoption Service as it may by Order determine.

3.2.6 Protection of Children (Jersey) Law 1994

a. This Law prohibits the taking of indecent photographs of children and penalises the possession, distribution, showing and advertising of such indecent photographs or pseudo-photographs.

b. Amendments were introduced to this Law in 1997 and 1999

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[78] Ibid

(i) Protection of Children (Amendment) (Jersey) Law 1997

a. This Law amended the 1994 Law to include taking or making of indecent photographs or pseudo-photographs and also penalised the possession, distribution, showing and advertising of such indecent photographs or pseudo-photographs.

b. All articles of the 1994 Law were amended to include both taking and making of photographs or pseudo-photographs.

3.2.7 Transfer of Functions (Health and Social Services Committee) (Jersey) Act 1995

a. This Act transferred all of the functions of the Education Committee under the following legislation to the Health and Social Services Committee:

(i) Article 12 of the Westaway Trust (Jersey) Law 1930, as amended

(ii) The Adoption (Jersey) Law 1961, as amended

(iii) Article 2 of the Children's Benefit Funds (Jersey) Law 1969

(iv) The Children (Jersey) Law 1969, as amended with the exception of functions relating to the provision of remand centres (Article 2) and Nurseries and Child-minders (Part VII).

(v) Article 10 of the Criminal Justice (Young Offenders) (Jersey) Law 1994

(vi) All other functions relating to the protection and welfare of children which are performed on behalf of the Education Committee by the Children's Service.

3.3 2000 to present

3.3.1 Events leading up to the introduction of the Children (Jersey) Law 2002

a. This section covers the development of the Child Care Laws that were brought into force in Jersey, largely as a result of the introduction of the Children Act 1989 in the UK and a growing recognition that the Children (Jersey) Law 1969 was no longer fit for purpose.

b. At a meeting on 8th June 1989, in response to the introduction of the Children Act 1989 in the UK the Attorney General requested Stéphanie Nicolle, then Crown Advocate and Anton Skinner, Children's Officer, to prepare a review of Jersey's Children's Law. This work was done in draft by Advocate Nicolle and sent to the Children's Officer in February 1991, who summarised it in the form of a report, which was to act as a drafting brief for the proposed changes to the Adoption (Jersey) Law 1961 and the Children (Jersey) Law 1969 and the drafting of necessary subordinate legislation. The report[79] set out six areas for reform:

(i) Power of the Education Committee to act as an Adoption Agency;

(ii) Freeing for adoption / dispensing with consent;

(iii) Access to adoption records;

(iv) Child Assessment Orders;

(v) Parental responsibility, custody and access;

(vi) Care Orders in criminal proceedings.

c. It was put before the Education Committee on 27th March 1991 when the Committee "*decided to request the Law Draftsman to prepare the proposed amendments to legislation relating to the care of children and requested the Children's Officer to forward an appropriate brief, together with copies of the relevant United Kingdom legislation to the Law Draftsman.*"[80]. Further amendments were later added which would provide for the cross border transfer of Care Orders and the recovery of children abducted from local jurisdictions throughout the UK[81].

d. In early 1992 the Law Draftsman produced a first draft of the proposed amendments under the title of Children (Amendment No. 5) (Jersey) Law 199-. In the accompanying note, the Law Draftsman expressed misgivings about amending existing legislation rather than producing a new Law. Despite this there were a number of re-drafts throughout 1992. However, in

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[79] Report dated 20.3.91, entitled 'Child Law Reform' **[RW59]**
[80] Education Committee minutes of meeting dated 27th March 1991 **[RW60]**
[81] Education Committee minutes of meeting dated 11th September 1991 **[RW61]**

January 1993 the Law Draftsman wrote in a letter to the Children's Officer[82] -

"It is always risky to adopt legislation from another jurisdiction on a piecemeal basis, and the risk is heightened when the legislation is as long as the Children Act. At the outset, it was not possible to specify the kind if problems which were likely to arise, but, as our draft has developed, some of these have become easier to identify."

e. The Law Draftsman then went on to list some of the anomalies in his letter. The Children's Officer responded to these concerns but stated that he felt the problems were surmountable, whilst recognising that he may be "unduly optimistic". He acknowledged the difficulty of fitting major elements of new legislation into an old Law but felt that it would not be possible to "*embrace the 1989 Act without taking on the new concept of parental responsibility and all the implications this may have for various parts of our local legislation.*"[83].

f. The Law Draftsman opened his response in February 1993 "*Try as I may, I am unable to convince myself that the 1969 Law is the appropriate legislative vehicle to accommodate such fundamental and far-reaching amendments.*"[84]. Although the Law Draftsman continued to work on the amendments, there continued to be a difference between his views and those of the instructing Department, who favoured a middle route, in the hope that it would be a quicker way of securing the identified amendments needed, rather than bringing in an entirely new Law.

g. In recognition of this, the Law Draftsman suggested dealing with the more difficult aspects of the amendments separately. However, in August 1993 in his response to a request from the Assistant Director of the Education Department to include a further amendment of the Children (Jersey) Law 1969, the Law Draftsman informed her that the draft was currently "on hold" until he received further instruction due to his concern, shared by the Children's Officer and the Crown Advocate, that "*if the amendments are proceeded in their present form, the principal Law as a whole may be*

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[82] Letter dated 11th January 1993 from Law Draftsman to Children's Officer **[RW62]**
[83] Letter dated 25th January 1993 from Children's Officer to Law Draftsman **[RW63]**
[84] Letter dated 8th February 1993 from Children's Officer to Law Draftsman **[RW64]**

rendered virtually incomprehensible to all but the few who are directly concerned with its administration."[85].

h. This position continued, as recorded in a handwritten file note by Crown Advocate Nicolle of a meeting with the Children's Officer dated 21st October 1993. However, by April 1994, in a letter to the Chief Adviser to the States about the Law Drafting Programme for 1994/95[86], the Children's Officer referred to the Children Law amendments and said that although the Department had resisted the proposal for a new Law as suggested by the Law Draftsman, for "*purely practical reasons i.e. whilst it was thought there was a good chance of realising amendments within a reasonable timescale it was feared that the enactment of a new Law would take a great deal of time to achieve. However as the Law Draftsman now feels that the amendments would take almost as long to produce as an entirely new Law I believe that there may be grounds for a compromise*". He concluded his letter by suggesting that he work with Advocate Nicolle, now the Solicitor General, to "*revise the original amendments to produce a brief for a new Law, based on the Children Act, 1989 [which would] afford an opportunity of perhaps producing a more comprehensive and fully up to date Children's Law.*"

i. In May 1994 the Children's Officer wrote to the Solicitor General, informing her that the Education Committee had agreed that a Working Party should be formed to look at the possible introduction of a new Children's Law to replace the 1969 legislation, appropriate to the Island's needs[87].

j. The first meeting of the Working Party on the Children's Law was held in June 1994, bringing together representatives from Day Care Services, Probation Services, Community Nursing Services, the Judicial Greffe, the Law Society and the Education Department. Prior to the meeting, the Children's Officer circulated a copy of the Children's Act 1989, which was

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[85] Letter dated 23rd August from Law Draftsman to Education Officer, with following attachments: Letter dated 23rd August 1993 from Law Draftsman to Assistant Director, Education Department; letter dated 12th August 1993 from Assistant Director, Education to Law Draftsman; Note entitled "Amendments to the Childrens Law" by J. Davies-Bennett dated 10/05/93; Note for Law Draftsman entitled "Child Law Reform" by J Davies-Bennett dated 28/04/93 **[RW65]**

[86] Letter dated 28th April 1994 from Children's Officer to Chief Adviser to the States entitled "Re: 1994/95 Law Drafting Programme" **[RW66]**

[87] Letter dated 18th May 1994 from Children's Officer to Solicitor General **[RW67]**

annotated with comments as to the implications of introducing each section locally[88].

k. At the meeting the members divided the various components of the UK Act into eight different sub-sections, which were allocated between the members of the group to review and prepare a paper for the next meeting with a suggested way forward.

Part 2: General principles

Part 3: Orders with respect to children in family proceedings

Part 4: Local authority support for children and families

Part 5: Care and supervision orders

Part 6: Emergency protection of children

Part 7: Residential care for children

Part 8: Arrangements for fostering children

Part 10: Welfare of children accommodated in independent schools, child-minders and day care of young children

l. The Group noted that Parts 2 and 3 of the Act were particularly important as they introduced new legal concepts to replace the old concepts of custody, care and control of children. The new concepts of parental responsibility, residence orders, contact orders, prohibited steps orders and specific issue orders extended the powers of the Court and the range of persons who might be enjoined to issues of the care and responsibility for children both within and outside marriage. The concept of parental responsibility shifted the emphasis in law from parents' rights to responsibility in respect of children.

m. It was also noted that whilst most of the facilities which Local Authorities had a statutory obligation to provide under Part 4 of the Act, for children deemed to be "in need", were already provided in the Island by the Children's Service, they were provided by means of Committee Policy and not Law, which meant that they were vulnerable to budgetary sanctions in times of financial constraint.

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[88] Meeting notes of Meeting of Working Party - New Children's Law, dated 27th June 1994 **[RW68]**

n. Similarly, in relation to Part 7, which covered persons and organisations providing residential care for children, it was noted that whilst Jersey had similar legislation in this regard, it was not as comprehensive or as clearly prescriptive as the equivalent UK legislation, which gave a local authority power to involve itself in issues of voluntary home appointments, management and record keeping.

o. The Working Party also agreed that the brief to be provided should not only cover the areas of the new Act, but should also look at the local situation to ensure that all the law considered necessary to protect and promote the care of children in the Island was covered, for example juvenile employment legislation. To this end the Children's Officer informed the group that he was in communication with a number of UK local authorities to ascertain views on the problems of implementing the Act and perceived gaps in provision for children which the Act might be failing to cover.

p. A second meeting of the Working Group was held in October 1994, where each sub-group presented the findings of their papers. The main topic for this meeting was the resource implications of introducing the proposed new provisions. The Children's Officer informed the group that "*if the Law had resource implications it would be necessary for the Education Committee to take the proposed Law to the States for approval in principle prior to more detailed briefing work and submission to the Law drafting schedule.*"[89]. The consequence of this scenario is that it could miss the time already allocated in the Law Drafting schedule.

q. One immediate outcome of the review was the recommendation by the sub-group working on the section of "*General Principles and Orders with Respect to Children in Family Proceedings*" to create a Family Division of the Royal Court. This recommendation was endorsed by the Deputy Bailiff[90]. The sub-group concluded that all of the principles of the main provisions of this Part of the Act were appropriate for local adaptation and dovetailed into the recent work and recommendations of the Working Party on Matrimonial Causes, however, would not be put into effective operation unless the recommendations of the latter were put into effect. This included the creation of a Family Division of the Royal Court, which would also

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[89] Minutes of the Meeting of the Working Party - New Children's Law, dated 3rd October 1994 **[RW69]**
[90] Letter dated 21st December 1994 from Deputy Bailiff to Deputy Judicial Greffier **[RW70]**

provide one place where matters concerning children could be heard and thereby rectify the current unsatisfactory position where children's matters were held in a number of different courts.

r. The Working Party held a third and final meeting in January 1995 (the minutes of which are missing from the Law Officers' Department files), from which the Children's Officer developed a report with recommendations which were approved by the Education Committee in February 1995[91]. The recommendations included:

(i) Amendments of the Children (Jersey) Law 1969 should be brought in as a new Law;

(ii) A new child custody law should be given priority (and put in the 1995/96 Law Drafting Programme);

(iii) The introduction of the new concept of parental responsibility, which impacts on the provisions of the 1969 Law dealing with care proceedings and the rights and duties of the Committee as a "legal parent" should be contained within the proposed new Law;

(iv) Any proposals that do proceed in a new Law should operate in tandem with the old 1969 Law;

(v) There should be a review of the remaining provisions of the 1969 Law and proposals submitted for a new Law (at some point in the future, in recognition of limited drafting resources);

(vi) The Committee should support the creation of a Family Division of the Royal Court within the creation of the Child Custody Law.

s. As a result of the agreed recommendations, the Solicitor General and Children's Officer were tasked with putting together a brief for the new Child Custody Law. It appears that there was very little progress on moving forward with this throughout 1995. The blockage appears to have been the availability of law drafting time, as confirmed by a letter from the Children's Officer to the Solicitor General in November 1995, in which he stated "*there appears to be no immediate urgency for work to commence on*

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[91] Letter dated 23rd February 1995 from Children's Officer to Solicitor General with Report attached (page 2 missing) **[RW71]**

a more detailed child law brief as it is unlikely to surface on a draftsman's desk until late next year."[92].

t. The Children's Officer and Solicitor General worked on the brief throughout in 1996, with an initial draft produced in October 1996 followed by a General Statement and Detailed Law Drafting Instructions produced by the Solicitor General in consultation with the Children's Officer in February 1997.

u. During this time, the Solicitor General also received requests or revived historic requests to include provision for the following:

(i) UN Convention on the Rights of the Child;

(ii) Hague Convention on the Civil Aspects of International Child Abduction;

(iii) Council of Europe Convention on Recognition and Enforcement of Decisions relating to Custody of Children;

(iv) Overseas Adoptions[93];

(v) European Convention on the Legal Status of Children born out of Wedlock[94].

v. At its meeting of 7th May 1997 the Health and Social Services Committee considered a report from the Children's Officer together with a draft brief explanatory note dated 29th April 1997 prepared by the Solicitor General, regarding the proposed Child Custody Law. The paper identified for the Committee those provisions in the Draft Detailed Instructions which were not covered by any previous Committee approval and asked the Committee to decide whether or not it wished those provisions to be included in the brief to the Law Draftsman.

w. The Committee agreed with all of the recommendations put forward in the report with the exception of the provision that a child should have the right to make an application to the Court or those provisions for the services for families. The Committee further agreed that the relevant bodies should be

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[92] Letter dated 20th November 1995 from Children's Officer to Solicitor General **[RW72]**
[93] Exchange of letters between Children's Officer and Solicitor General, dated 20th November 1995 and 4th December 1995 **[RW73]**
[94] Legislation Committee Act, 14th March 1997 **[RW74]**

given an opportunity to consider and comment upon the Detailed Instructions at an early stage.

x. Following on from the meeting the Solicitor General amended the draft Detailed Instructions in two respects: firstly, to ensure that the new statute would completely replace the customary law position with regard to the custody of children; secondly, in relation to the question of guardianship, to add a section to provide that where circumstances specified in section 5(1) of the 1989 Act exist (*i.e.* the appointment of guardians) a person may apply to the Court for parental responsibility for the child, and also that a parent who has responsibility for his child may appoint another individual to assume parental responsibility for the child in the event of the parent's death. The way the law as to *tuteurs*, which dealt with legal responsibility for a child's financial affairs, remain unchanged.

3.3.2 Children (Jersey) Law 2002 (plus associated orders, regulations and rules)

(i) Introduction

a. The Children (Jersey) Law 2002 incorporates many of the concepts of the United Kingdom Children Act 1989, adapted to suit the needs of Jersey.

b. The draft Children (Jersey) Law 200- was lodged au Greffe on 18th December 2001 by the Health and Social Services Committee. The Report[95] that accompanied the draft Law opened with the following paragraph -

"*The purpose of this draft Law is to replace the Children (Jersey) Law 1969 with new provisions governing all aspects of the care of, and responsibilities towards, children. The original intention was to revise only those aspects relating to the rights and responsibilities of parents with respect to their children, but it became apparent that it was impracticable to graft new concepts onto a Law that is now over thirty years old and based on even older United Kingdom legislation which had long since been repealed. It was therefore considered preferable to produce a comprehensive new Law, based on the United Kingdom Children Act 1989,*

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[95] Report on the Draft Children (Jersey) Law 200-, Lodged au Greffe on 18th December 2001 by the Health and Social Services Committee **[RW75]**

that could address the deficiencies in the existing Law and create a legal framework capable of responding to the wide variety of child care arrangements that exist today.".

c. Two other new Laws that dealt with child-related matters were introduced at the same time, although these fell outside the responsibility of the Health and Social Services Committee. Firstly, the Day Care of Children (Jersey) Law 2002, which covered those aspects of the 1969 Law administered by the Education Committee, to regulate the care of children during the day in nurseries, playgroups and by child-minders. Secondly, the Criminal Justice (Evidence of Children) (Jersey) Law 2002 which contained the provisions of the 1969 Law dealing with the presence in court of, and the giving of evidence by, children. The new concepts contained within the 1989 Act also required amendments to the Adoption (Jersey) Law 1961, which were provided for in the Adoption (Amendment No. 5) (Jersey) Law 2002.

(ii) Delay in bringing in the Children (Jersey) Law 2002

a. The Law was adopted by the States on 26th February 2002 and came into force on 1st August 2005. This delay of 3½ years from passing to coming into force was the source of concern for some Politicians including the President of the Health and Social Services Committee at the time[96]. However, before it could be brought into force, considerable subordinate legislation was required; two sets of Regulations, two Orders and three sets of Rules of Court, listed below, were needed in order for the Law to become fully operational.

(i) Children (Contact in Care) Regulations 2005

(ii) Children (Placement) (Jersey) Regulations 2005

(iii) Children (Secure Accommodation) (Jersey) Order 2005

(iv) Children (Voluntary Homes) (Jersey) Order 2005

(v) Children Rules 2005

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[96] Email correspondence between Senator S Syvret (President of the Health and Social Services Committee), Attorney General, Solicitor General, Senator T Le Sueur and Anton Skinner (Children's Officer) dated between April and July 2004 **[RW76]**

(vi) Children (Prescribed Classes of Applicant to Vary Directions) Rules 2005

(vii) Children (Parental Responsibility Agreement) Rules 2005

b. This constituted a considerable input of time and effort on the part of the Law Draftsman's Office and the Law Officers' Department which is responsible for drafting Rules of Court. As the Health and Social Services Department explained *"the original delays were caused by a series of personnel issues (staff departures and long term sickness) involving the persons assigned the tasks, which placed a great strain on the resources of both the Crown Officers and the Law Draftsman's department.*". He also informed the Minister "*As you know the UK Children's Act 1989 - despite large teams of lawyers and administrators in the Lord Chancellor's Department and Department of Health being devoted to the task full time - did not come into force until October 1991, over 2 years from the date it received Royal Assent. Despite the limited resources we have available locally the timescale will be no longer.*"[97]. First drafts of the Regulations and Orders were produced for comment and consultation in June 2004[98]; the Regulations were made by the States in July 2005 and came into force on 1st August 2005 at the same time as the Children (Jersey) Law 2005, the Orders mentioned above and the Day Care of Children (Jersey) Law 2002, the Criminal Justice (Evidence of Children) (Jersey) Law 2002 and the Adoption (Amendment No. 5) (Jersey) Law 2002.

c. Brief explanations of the regulations, orders and rules are provided below -

(iii) Children (Contact in Care) Regulations 2005

a. The Regulations brought into force the provision regarding the steps to be taken by the Health and Social Services Minister in relation to contact (formerly known as access) between a child in care and his or her parents, or other relevant parties. The Children Law introduced a new court order, the Contact Order (Article 27 of the Children Law), which dealt with arrangements for children living apart from their family to have continuing contact with their parents and other significant parties. These Regulations

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[97] Email correspondence from Anton Skinner to Stuart Syvret (Minister for Health and Social Services) dated 2nd June 2004. **[RW77]**

[98] Memorandum dated 4th June 2004 from L. Marsh-Smith, Assistant Law Draftsman to Danny Wherry, Children's Department, Health and Social Services **[RW78]**

set out the steps to be taken when contact for a child in care is being arranged. The aim is to ensure that, except in exceptional circumstances, the views of parents and others are taken into account and they are kept properly informed of the arrangements made for contact whilst the child remains in care.

(iv) ***Children (Placement) (Jersey) Regulations 2005***

a. These Regulations provide a framework of provisions governing the provision of accommodation and maintenance by the Minister for Health and Social Services for children it is under a duty to look after under Article 22 of the Children Law[99]. They govern placement with family and others as well as foster parents.

b. The Regulations combine, with some drafting changes, the relevant provisions of the UK's Arrangements of Children (General) Regulations SI 1991/890 (as amended by SI 2002/546), the Placement of Children with Parents *etc.* Regulations SI 1991/893 and the Foster Placement (Children) Regulations SI 1991/910. Even though the Foster Placement Regulations had been repealed and replaced with the Fostering Services Regulations SI 2002/57, it was decided that the 2002 Regulations were too detailed and relied too much on powers from other UK legislation and therefore the earlier Regulations were more appropriate to Jersey with the services provided by one authority.

(v) ***Children (Secure Accommodation) (Jersey) Order 2005***

a. The purpose of this Order was to make further provision with respect to the keeping of children in secure accommodation under Article 22 of the Children Law. It is based, in part, on UK SI 1991/1505 (as amended by SI 1992/2117).

(vi) ***Children (Voluntary Homes) (Jersey) Order 2005***

a. The purpose of this Order was to prescribe standards for the running of voluntary homes and regulate the placement of children in them under Articles 56 and 81 of the Children Law. The aim was to ensure that children cared for in such settings received care of a sufficiently high

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[99] Act of the Health and Social Services Committee, dated 4th July 2005 **[RW79]**

standard so as to meet their needs and protect their welfare[100]. The majority of this Order was taken from the Children's Homes Regulations, UK SI 1991/1506.

(vii) Children Rules 2005

a. These Rules of Court were brought into force by the Superior Number of the Royal Court in pursuance of Article 67 of the Children Law. The Rules provide a comprehensive guide as to the procedures to be followed in any relevant proceedings, including the timing and manner in which any application is to be made. They also set out the persons entitled to participate in any relevant proceedings and in what capacity, the documentation required and the form that such documentation must take.

(viii) Children (Parental Responsibility Agreement) Rules 2005

a. These Rules of Court were brought into force by the Superior Number of the Royal Court in order to set out the steps to be taken to secure a parental responsibility agreement under Article 5(3) of the Children Law. The Schedule to these Rules provides a form that applicants must use to make an application to the court for a parental responsibility agreement.

(ix) Children (Prescribed Class of Applicant to Vary Directions) Rules 2005

a. These Rules of Court provide the persons who may apply to the Court to vary directions made on making an interim care or supervision order: they also make similar provisions as to the variation of directions given when an emergency probation order is made.

3.3.3 Day Care of Children (Jersey) Law 2002

a. This Law re-enacts with some amendments Part VI of the Children (Jersey) Law 1969 as part of the process of updating the 1969 Law. As this part of the 1969 Law was administered by the Education Committee, a decision was taken to regulate the provision of day care of children by means of a separate Law administered by the Education Committee. It was presented to the States as part of a package with the Children (Jersey) Law 2002 and the Criminal Justice (Evidence of Children) (Jersey) Law 2002. Whilst the fundamental principles of the 1969 Law remained the same, the new Law

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[100] Act of the Health and Social Services Committee, dated 21st July 2005 **[RW80]**

provided the opportunity to make some changes to the arrangements in childcare provision at that time and incorporate some of the provisions of the UK Children Act 1989.

b. The new Law sought to introduce more clarity to the requirements of and definitions for the existing scheme of registration and, where appropriate, to improve child safety by bringing certain areas of the 1969 Law in line with current local and UK good practice. The Law also introduced an increased upper age limit of twelve years, in relation to both day care providers and provisions, bringing both the Law and the registration scheme in line with the principles approved by the States when it agreed the establishment of the Child Care Trust and the introduction of child care allowance and tax relief schemes which were also introduced shortly before this Law was put before the States.

c. Article 3 was particularly significant as it introduced a new provision prohibiting a person from being involved with day care accommodation or acting as a day carer if he is disqualified under the Children (Jersey) Law 2002 from being involved with a voluntary home or acting as a foster parent.

d. Article 10 of the Law included a new provision enabling the Royal Court to order a Committee decision to have immediate effect where it is satisfied that a child who is being, or may be, looked after in day care accommodation or by a day carer is suffering, or is likely to suffer, significant harm.

3.3.4 Adoption (Amendment No. 5) (Jersey) 2002

a. This Law amended the Adoption (Jersey) Law 1961. As well as updating the principal Law with the relevant new concepts of the Children (Jersey) Law 2002, one of the main matters that this Law sought to address was to facilitate adoptive applicants' access to overseas adoption opportunities, as well as adoption placements under UK law in other parts of the British Isles. In so doing, this addressed a local problem as the number of children becoming available locally for adoption had diminished sharply in the years prior to this amendment being brought into force and couples wanting to adopt had begun exploring the possibility of adopting children from overseas. The amendment also resolved a problem of local domicile that existed in Jersey at that time which facilitated adoption by people resident

in Jersey who remained UK-domiciled because they were on temporary employment contracts.

b. The Hague Convention on Inter-country Adoption[101] provided an international framework setting out standards and requirements in respect of the process of adopting a child resident in a different country. The UK signed up to this Convention in 1995 and asked Jersey whether it wished the UK ratification of the Convention extended to the Island. After a considerable amount of discussion and correspondence between the Law Officers' Department and other relevant States Departments it was decided to implement the framework by means of domestic legislation. These amendments to the Adoption (Jersey) Law 1961 enabled Jersey to satisfy the requirements and participate in the Convention arrangements[102]. The Convention has not yet been extended in full to Jersey, but work is currently in hand to put in place the enabling legislation for that to occur.

3.3.5 Child Custody (Jurisdiction) (Jersey) Law 2005

a. The Report[103] that accompanied this Law when it was lodged au Greffe, comprehensively described its provisions and purpose and the impact of bringing it into effect. An edited version of this report is produced below -

b. This Law is a private international law measure. Its provisions are similar to those of the Family Law Act 1986 of the United Kingdom which set out a new statutory code laying down the jurisdictional bases for the granting of custody orders in England and Wales, Scotland and Northern Ireland to provide an established procedure for reciprocal recognition and enforcement of custody orders in each part of the United Kingdom, regardless of where made.

c. One of the main purposes of this Law is to make Jersey's legislation consistent with this statutory framework for reciprocal recognition and enforcement of custody orders. In relation to Guernsey, the Isle of Man or any British Overseas Territory, the States would be empowered by Regulations to amend or supplement the Law as necessary to enable there to

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[101] Hague Convention on Protection of Children and Co-Operation in respect of Intercountry Adoption (full title)
[102] Report accompanying the Draft Adoption (Amendment No. 5) (Jersey) Law 200- **[RW81]**
[103] Report accompanying the Draft Child Custody (Jurisdiction) (Jersey) Law 2000-, lodged au Greffe on 7th June 2005 by the Legislation Committee **[RW82]**

be such reciprocal recognition and enforcement of custody orders as between Jersey and those jurisdictions.

d. In line with the UK Family Law Act 1986, Articles 17 and 18 of the Law conferred wider powers on the Royal Court to order disclosure of a child's whereabouts or to order the recovery of a child. The Royal Court is also able to give direct effect to orders made by a court in the United Kingdom prohibiting the removal of a child from the jurisdiction. This enables the removal of the anomaly whereby a restriction imposed by a court in another part of the British Islands on taking a child abroad is of no effect in Jersey.

e. As part of its enforcement powers, the Royal Court is able to require a person to surrender any British passport issued to or containing particulars of the child.

f. The Law also makes provision for a child who moved outside Jersey to be treated in certain circumstances as though he or she was still habitually resident in Jersey. This is designed to deter the unauthorised removal of a child from one jurisdiction to another for the purpose of delaying enforcement of a custody order, or initiating or re-opening custody proceedings in a forum which the person removing the child thinks would be more favourable to him or her.

g. This Law was lodged at the same time as the Child Abduction and Custody (Jersey) Law 2005 and the Criminal Law (Child Abduction) (Jersey) Law 2005. Taken together they completed a statutory framework for the better safeguarding of children against the harm and disruption caused to them by abduction or by arbitrary removal from one jurisdiction to another.

h. Until the enactment of this legislation, Jersey's statutory framework in this area had been somewhat insular. With the bringing into force of the Children (Jersey) Law 2002 and the enactment of this subsequent legislation, the legal structures of the Island in matters concerning the welfare of children were reformed in such a way that the Jersey courts and child welfare bodies are able to operate fully and effectively at the international level.

3.3.6 Child Abduction and Custody (Jersey) Law 2005

a. The Report[104] that accompanied this Law when it was lodged au Greffe, comprehensively described its provisions and purpose and the impact of bringing it into effect. An edited version of this report is produced below -

b. In response to the increased number of child abductions, this Law was brought in to help parents and others with custody rights to obtain the return of abducted children. This is achieved by enabling the United Kingdom, on the Island's behalf, to ratify and the Island to implement two international Conventions:

   i. The Hague Convention which requires the summary return of an abducted child to its country of habitual residence so that issues of custody can be decided there; and

   ii. The European Convention which enables custody decisions that have already been made to be recognised and enforced.

c. The Hague Convention prevails should both Conventions apply to the case of an abducted child.

d. This Law supplemented the criminal sanctions for child abduction in the Criminal Law (Child Abduction) (Jersey) Law 2005 against people who take children abroad without permission by providing a civil procedure for securing the return of those children.

e. The Law marked a significant departure from the reliance of the Royal Court on the customary law in this field. It enabled Jersey to co-operate with all contracting States and enabled Jersey in turn to secure co-operation from those States. The procedures are clearly set out along with the criteria according to which applications are determined. The Law would help to curtail the potential for protracted litigation resulting in a reduction in the cost and above all the delay and uncertainty associated with the restoration of abducted children to their custodial parent.

f. When the Law was placed before the States it was acknowledged that this fundamental reform, which finally enabled the Island to take its place in the

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[104] Report accompanying the Draft Child Abduction and Custody (Jersey) Law 2000-, lodged au Greffe on 7th June 2005 by the Legislation Committee **[RW83]**

wider international community, played a full part in combating cross-border abduction of children, was long overdue.

PART 4: VARIOUS SPECIFIC QUESTIONS ADDRESSED

Before making this statement, I was asked by Counsel to the Inquiry to address various specific issues which Counsel thought might be relevant to the task of the Inquiry. These (and my answers, so far as I am able to provide them), are as follows -

4.1 The process of legislative change in Jersey

*[explanation of the **process** for introducing legislation in Jersey since 1945 and how that process has evolved through to today's date - how a law gets into the books - development of policy - as at 2014 : green paper □ white paper □ consultation (extent of)]*

4.1.1 1945 - 2005

a. Since 1771, the States Assembly has been the sole legislative body in the Island with full plenary powers. Until 2005, (except for a period during the Occupation) the administration of Jersey was in the hands of delegations of the States Assembly called Committees. From 1946, they comprised solely elected members of the States and mostly consisted of a President and 6 other members. Each Committee had responsibility for an area of administration, broadly reflected in its name or title - in recent times some of these were the Public Services Committee, Education Sport and Culture Committee or Health and Social Services Committee, for instance. They had both statutory responsibilities and powers and a variety of other duties and responsibilities which were non-statutory.

b. Though I cannot speak with direct experience of the period before 1989, I believe it is accurate to say that, as a general rule, each Committee was responsible for making sure that it had legislative powers which were adequate and up to date so as to enable it to perform its functions. If new legislation was felt to be needed, either by the Officers of the Committee or by the Committee itself, the Officers would put a paper to the Committee, asking the Committee to approve the preparation by the Law Draftsman of a draft of the legislation, on the instructions of the Officers. The Law Draftsman's office at that time was a part of the States Greffe. Until the

1980s the same person was both Greffier (Clerk to the States Assembly) and Law Draftsman.

c. Sometimes the Committee might be asked to approve the drafting brief itself; it would always be asked to approve the draft legislation for lodging "*au Greffe*" in the form of a *Projet de Loi.* Each Committee would therefore bring forward a proposal for new legislation to the States in respect of its own area of responsibility.

d. An example of this in practice is the correspondence between 1952 and 1956 between the Elizabeth House Committee, the Public Instruction Committee and the Law Officers about two potential additional amendments to the *Loi appliquant à cette Île certaines des dispositions de l'Acte de Parlement intitulé* "Children and Young Person's Act, 1933" (23 Geo. 5, ch 12): firstly, whether to allow the Royal Court to send female offenders to Elizabeth House as an alternative to sending them to an "Approved School", and secondly, whether to extend the age limit that the Royal Court was empowered to order a child to remain in an institution to from 18 to 21. As can be seen from the correspondence, both of these proposed amendments were subsequently rescinded[105].

e. It is difficult to judge how often and to what extent there was a process of public consultation in the early post war period on proposed new legislation. My general impression is that the frequency and effectiveness of consultation has grown over the years.

f. Unlike the situation in the UK Parliament, in theory, any States Member could, and indeed still can, bring his or her own Proposition to the States asking for new legislation to be introduced, with a reasonable prospect of success. If such a proposition was adopted, a Committee would be charged with responsibility for bringing forward the draft of the legislation to the States. There was also a Legislation Committee, which had responsibility for legislation which was not within the remit of a particular Committee.

g. It is not known to me to what extent, if any, there was a co-ordinated government plan for new legislation in the 1950s and 60s but I believe things began to change during the 1970s when the first Policy Advisory

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[105] See correspondence from 1952 to 1956 between the Elizabeth House Committee, the Public Instruction Committee and the Law Officers **[RW84]**

Committee was appointed, (see Appendix II) and developed further with the creation of the Policy and Resources Committee in 1989. Fairly shortly thereafter (probably 1991 or 1992) the first legislation programme was drawn up. This certainly assisted with prioritisation of new legislative proposals and with planning the use of the law drafting resources.

4.1.2 Post 2005 - Ministerial Government

a. In 2005, following the coming into force of the States of Jersey Law of that year, Jersey moved to a form of Ministerial government, with a Chief Minister and nine other Ministers forming a Council of Ministers. One of the specific responsibilities of the Council is the prioritisation of executive and legislative proposals (Article 18(2)(d) of the States of Jersey Law 2005). The Council's function in this area is to decide on the priorities of the legislative proposals put forward by the various Ministers. These are then submitted to Scrutiny Panels and to the States for consideration and approval as a part of the Council's policy proposals. The Legislation Committee has survived in the form of the Legislation Advisory Panel, which is chaired by an Assistant Minister in the Chief Minister's Department and reports to the Chief Minister.

b. In addition to and in support of this more formalised and organised political structure, a committee of Chief Officers in the various Departments has also been created - the Corporate Management Board - under the Chief Executive Officer which considers and approves proposals of various kinds, including for new legislation, before they are considered by the Council of Ministers.

c. Consultation with the public and/or with interested parties on proposals for new legislation is carried out on most new legislation and on all of the major projects. It may take the form of consultation on a policy proposal or on the draft of the legislation itself, or, on occasions, on both. New legislation is also often referred to the appropriate Scrutiny Panel either before it is lodged or, if not, during the course of its passage through the States (on Scrutiny Panels, see generally Part 7 of the Standing Orders of the States of Jersey). Scrutiny Panels are specifically charged with responsibility for scrutinizing draft Laws and subordinate legislation (see Standing Order 136).

4.2 The extent to which, if at all, English/UK legislation has provided a trigger for legislative change in Jersey

[generally; does Jersey "cherry pick" legislative changes from the UK, having seen how the legislation operates in practice : is there a process of consultation?]

a. There are many examples showing that Jersey closely follows UK legislation where appropriate. In some cases, changes to UK legislation provide a specific trigger for changes in Jersey legislation, in other cases there has been a general recognition that Jersey legislation requires updating. Correspondence within the files between the Home Office, Whitehall and the Attorney General shows evidence of a consultative approach to amendments to legislation and the introduction of new legislation. Examples are provided below -

4.2.1 Children and Young Persons Act 1933

a. In a letter dated 5th September 1934, from the Attorney General to the President of the Committee of Legislation in relation to the "*coming into force in England of the Children and Young Persons Act, 1933* (23 Geo.5 ch.12)", the Attorney General stated: "*It is, in my opinion, clear that the coming into force of [the Children and Young Persons Act 1933] makes it essential that the* "Loi *(1896)* sur la détention de jeunes enfants *&ca.*" should be repealed and replaced by a new local law the provisions of which should be in harmony with the material provisions of the English law."[106].

4.2.2 Children (Jersey) Law 1969

a. The trigger for this law was a general recognition that Jersey's child care legislation required updating. See, for example the report referred to in Section 3.2.2, reference RW25 entitled "Suggested new children's legislation" which listed the legislation that Jersey's new children's legislation should be built on. The tables referred to in RW26 listed these laws and showed how the provisions of each were adapted to suits Jersey's own legislative requirements.

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[106] See RW1

4.3 Is Jersey alerted to legislative changes taking place in the UK?

[and if so what is the process or does Jersey maintain a constant review of UK legislative changes : in effect, does Jersey both initiate and react?]

a. As discussed already above, correspondence between the Home Office, Whitehall and the Attorney General within historic files shows evidence of extensive consultation between the Jersey and UK authorities when developing new legislation, for example the Children's Department of the Home Office provided substantial comments and feedback during the development of the Children (Jersey) Law 1969 (see references RW30 - RW51).

b. In relation to whether Jersey was alerted to legislative changes taking place in the UK, it appears that the Law Officers' Department was only alerted by the Home Office to such changes that would require a consequent change locally to legislation and / or procedures.

c. An example of this has already been mentioned above in Section 3.1.1(i)(d) in relation to the Adoption of Children (Amendment No. 2) (Jersey) Law 1959, when the definition of "abroad" was amended to mean 'outside the British Isles' to reflect the amendment of the adoption law in England and Wales that Jersey would no longer be regarded as "abroad" for the purposes of the Adoption Act 1950[107]. Similarly, as discussed in Section 3.2.2 and 3.2.3, the Home Office alerted the Jersey authorities very early in the process of its plans to abolish Approved Schools in England and Wales, as it clearly recognised that Jersey would need to bring about both administrative and legislative changes locally.

d. As the process for legislative change in Jersey is such that, up until 2005, each Committee brought and, since 2005, each Minister brings, forward proposals for new legislation to the States in respect of its own area of responsibility, it is likely that the relevant Departments keep under review prospective changes in UK law, as a matter of good practice. Indeed there is regular contact between Jersey Departments and UK equivalents about their common areas of responsibility and I would expect that this contact

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[107] Exchange of letters between A.D. Gordon-Brown, Home Office and C.S. Harrison, Attorney General, dated 28th June, 1957 **[RW10]**, 6th August, 1957 **[RW11]** and 26th August, 1957 **[RW12]**.

would include information about changes in UK legislation at an early stage.

e. I think that it is also worth mentioning that improvements in information technology have made a vast difference to the ease with which proposed changes in UK law come to attention.

f. One recent major change in the way the relationship between Jersey and the UK works should be noted. The UK Ministry with responsibility for the Crown Dependencies is no longer the Home Office. Since 2007 it has been, first, the Department for Constitutional Affairs and more recently the Ministry for Justice. The point of contact in the Islands has also changed and nowadays, instead of using the Official Channel for correspondence, which went to and from the UK via the Lt Governor and the Bailiff's Chambers, much of the communication between MoJ and the Insular authorities is now less formal and is either through the Chief Minister's Department or direct with Jersey Departments. These arrangements are described in more detail in the Justice Select Committee Report on the Crown dependencies of 30th March 2010 (HC56-1).

g. On occasions, where an Act of Parliament has been extended partly or wholly to Jersey by Order in Council, the Chief Minister's Department, in its co-ordinating role for contact with UK Government Departments, will be notified by the UK officials of the prospective changes and asked whether Jersey wishes to have a permissive extent provision in relation to them.

4.4 Specifically, since 1945 the extent to which UK child care legislation has been mirrored by Jersey law

a. Almost all child care legislation in Jersey mirrors UK child care legislation to some extent, although it incorporates only those provisions relevant to Jersey to reflect far fewer administrative layers within a much smaller jurisdiction. However, without carrying out a comprehensive review of UK child care legislation since 1945 it is not possible to say whether Jersey law mirrors all UK child care legislation; in fact I believe that other witnesses in the Inquiry may give evidence on this topic.

4.5 Consider, by reference to child statutory legislation and regulations since 1945 those instances where legislative change in relation to child care has been triggered by circumstances specific to Jersey (*e.g.* adoption immediately after the war) **and those instances where legislative change in Jersey has been prompted by legislative change in the UK** (*e.g.* UK Children Act 1989/Children (Jersey) Law 2002)

4.5.1 Legislative change triggered by circumstances specific to Jersey

a. ***Adoption of Children (Jersey) Law 1947*** - the documents found in relation to this Law[108], set out the reasons for introducing this Law, which was to provide persons who bring up children who are not their own, with "*assurance that the care, expense and attention which they give to the adopted child will not be lost and that the natural parent will not step in whenever it suits him to do so.*" It acknowledged in those documents that the attempts at that time to afford this security by placing the child under the guardianship of adopters was not effective as the father and widowed mother still retained the right to custody unless a court decided otherwise. It is also acknowledged further that "*It should be stated that some persons, in order to adopt children, have obtained adoption orders in England, and it is absolutely wrong that any person domiciled in Jersey should have to set up a fictitious domicile in order to obtain a remedy which should be obtained under the control of the Jersey court*".

b. Specifically, this related to the post-war situation, where families had taken in illegitimate children and lived in fear that the purported father might return and try to re-claim the child.

c. Jersey has also, at times, maintained differences in legislation between the UK and Jersey, for example in relation to the age of eligibility to adopt under the Adoption (Jersey) Law 1961. At a meeting of the Health and Social Services Committee on 5th June 1996, it was agreed that the definition of "infant" in Article 1 of the Law would be amended to reflect the reduction of the age of majority in Jersey from 20 to 18 years, however, the Committee, having satisfied itself that the current adoption requirements relating to the age of adopting individuals were satisfactory, decided not to

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108 Undated notes entitled "Notes on Adoption of Infants Bill" **[RW85]**

mirror the lower age of eligibility to adopt in the UK Adoption Bill at that time[109].

4.5.2 Legislative change in Jersey prompted by legislative change in the UK

See answer to 4.3 above.

The introduction of the Children Act 1989 prompted the Attorney General to request Crown Advocate, Stéphanie Nicolle and Children's Officer, Anton Skinner to prepare a review of Jersey's Children's Law[110]. This is explained in detail in Section 3.3.1 above.

4.6 Consider, if there has been mirror legislation, the lead time between the UK legislation and the Jersey law: what accounts for the time span

a. The Children (Jersey) Law 1969 was largely based on the Children Act 1958. As discussed in Sections 3.2.2 and 3.2.3 above, the first draft of Jersey's 1969 law was sent for comment to the Home Office in 1965, but did not come into force until 1st September 1970. The main reason for this delay was the need to reflect in Jersey law the complete overhaul of the UK criminal justice system for young offenders and the fact that the Children's Department of the Home Office, who were providing comments on the draft Jersey Children's Bill was occupied with bringing in the UK's own changes to child care legislation at that time. In the end Jersey brought in its own legislation in full knowledge that an amendment would be required immediately in relation to Approved Schools, rather than delay the full Law any further.

b. Similarly, the Children (Jersey) Law 2002 was largely based on the Children Act 1989 with adaptations considered appropriate for Jersey. Whilst it is difficult to generalise about the reasons why there is a time lag, in some instances, between the passage of UK legislation and its being mirrored in Jersey, amongst the likely factors might be the need to consider the extent of any adaptations, the fit of the new legislation with existing legislation in Jersey and the effect on the customary law. It may also be that for various reasons, some of the complexities found in the UK model will be unnecessary in a smaller jurisdiction such as Jersey. There may also

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[109] Act of the Health and Social Services Committee, dated 5th June 1996 **[RW86]**
[110] Letter dated 3rd July 1989 from Children's Officer to Deputy Law Draftsman **[RW87]**

sometimes be an element of the lack of local resources to address issues but it not easy to be specific about this.

4.7 Consider the contrast in regulatory provision in child care and the role of ministerial guidance in UK (Home Office guidance in 1940s-1970s; orange book guidance with the Children Act 1989) and its equivalent in Jersey

a. I am afraid that I cannot answer this question as I have not seen the Home Office guidance referred to and I am unaware of whether such guidance was made available to Jersey. Likewise, I have not seen any Jersey equivalent guidance. I would expect that those working in the Education and Health Departments dealing with child care matters would be better placed to answer this than I am. I can say that a review of the Law Officers' Department, States Greffe and Law Draftsman's Department files relating to the child care legislation did not bring to light any information on this; but of course there is a possibility that there could be information in other files not relating to the legislation, which were not reviewed for the purpose of proving my evidence.

4.8 Comment on whether where there is delay in implementing legislative change in Jersey this is a reflection of societal attitudes

a. I have already provided what evidence can be located in the files on the reasons for the delays in legislative changes. Unfortunately, I do not think that I am qualified to comment further on this question; it seems that it would be more appropriately addressed to a social historian of both Jersey and the UK.

Statement of Truth

I believe the facts stated in this witness statement are true.

Signed .....

Richard William Whitehead

Dated 2. 9. 2014.

Appendix I - List of legislation

Doc No	Document Description	Date
1.	The 'Loi appliquant à cette Ile certaines des dispositions de l'Acte de Parlement entitulé 'Children and Young Persons Act 1933', confirmed by Order of His majesty in Council of the twenty-first day of February 1935	1935
2.	"Brig-Y-Don Children's Convalescent and Holiday Home" Incorporation Law – in French	1939
3.	Loi autorisant le transfert au Public de cette Ile des immeubles appartenant à L'Asile dit : 'The Jersey Female Orphans' Home' *(Acte-Rapport du Comité d'Instruction Publique recommandant, conditionellement, d'accepter le transfert aux Etats de l'Institution dite : 'Jersey Female Orphans' Home,' aux termes et conditions y énoncés)*	1939
4.	The 'Loi (1940) concernant les témoinages d'enfants dans les poursuites criminelles'	1940
5.	The 'Loi (1940) sur la Protection de l'Enfance' *(repealed by Children (Jersey) Law 1969)*	1940
6.	The 'Loi pour investir le Comité d'Instruction Publique des droits paternels à l'egard des personnes qui ont été trouvées par la Cour Royale en besoin de protection et qui ont été envoyées à une Institution dans cette Ile', confirmed by Order of the tenth day of March 1947 of the Counsellors of State in Council on behalf of His Majesty	1947
7.	Adoption of Children (Jersey) Law	1947
8.	Public Instruction Committee Act 1953 (Conditions for the reception of children into the care of the Public Instruction Committee)	1953
9.	Public Instruction Committee (Change of Name) (Jersey) Act (changed to Education Committee, also ref to Westaway Creche)	1955
10.	Children (Criminal Proceedings) (Jersey) Law 1956	1956
11.	Criminal Justice (Jersey) Law 1957 – Art 2 and para 2 of Art 8	1957
12.	'Loi pour modifier la Loi (1935) appliquant à cette Ile certaines des dispositions de l'Acte de Parlement intitule 'Children and Young Persons Act 1933', confirmed by Order of Her Majesty in Council of the twentieth day of December 1957	1957

Doc No	Document Description	Date
13.	Adoption of Children (Amendment) (Jersey) Law	1957
14.	Adoption of Children (Amendment No.2) (Jersey) Law	1959
15.	Jersey House of Help (Transfer to Public) (Jersey) Law	1960
16.	Haut de la Garenne Act	1960
17.	Jersey Female Orphans' Home Law	1961
18.	Adoption (Jersey) Law	1961
19.	Adoption Rules	1962
20.	Adoption (Amendment) (Jersey) law	1963
21.	Adoption (Jersey) Law	1965
22.	Adoption (Amendment) (Jersey) Rules	1965
23.	Adoption (No.2) (Jersey) Law	1966
24.	Westaway Trust (Amendment No.2) (Jersey) Law	1966
25.	Children (Jersey) Law	1969
26.	Children's Benefit Funds (Jersey) Law	1969
27.	Children (Jersey) Law, 1969 (Commencement) Act	1969
28.	Children (Jersey) Law, 1969 (Commencement) (No. 2) (Jersey) Act	1970
29.	Children's (Boarding-Out) (Jersey) Order	1970

Doc No	Document Description	Date
30.	Children (Amendment) (Jersey) Law	1972
31.	Children and Young Persons (Designation of Jersey Order) Order	1972
32.	Children (Contribution Orders) (Jersey) Rules	1972
33.	Adoption (Amendment No.2) (Jersey) Rules	1974
34.	Children (Amendment No.2) (Jersey) Law	1974
35.	Children (Amendment No.3) (Jersey) Law	1978
36.	Children (Amendment No.4) (Jersey) Law	1986
37.	Westaway Trust (Amendment No.3) (Jersey) Law	1990
38.	Protection of Children (Jersey) Law	1994
39.	Adoption (Amendment No.3) (Jersey) Law	1995
40.	Transfer of Functions (Health and Social Services Committee) (Jersey) Act	1995
41.	Children (Amendment No. 5) (Jersey) Law	1996
42.	Protection of Children (Amendment) (Jersey) Law	1997
43.	Protection of Children (Amendment No.2) (Jersey) Law	1999
44.	Adoption (Amendment No.4) (Jersey) Law	1999
45.	Day Care of Children (Jersey) Law	2002
46.	Children (Jersey) Law	2002

Doc No	Document Description	Date
47.	Adoption (Amendment No.5) (Jersey) Law	2002
48.	Protection of Children (Amendment No.3) Jersey Law	2004
49.	Day Care of Children (Jersey) Law 2002 (Appointed Day) Act	2005
50.	Children (Jersey) Law 2002 (Appointed Day) Act	2005
51.	Children (Contact in Care) (Jersey) Regulations	2005
52.	Children (Parental Responsibility Agreement) Rules	2005
53.	Children (Placement) (Jersey) Regulations	2005
54.	Children (Prescribed Classes of Applicant to Vary Directions) Rules	2005
55.	Children (Secure Accommodation) (Jersey) Order	2005
56.	Children Rules	2005
57.	Children (Amendment) Rules	2005
58.	Children (Voluntary Homes) (Jersey) Order	2005
59.	Child Custody (Jurisdiction) Rules	2005
60.	Child Custody (Jurisdiction) (Jersey) Law	2005
61.	Child Abduction and Custody (Jersey) Law	2005
62.	Children and Day Care (Amendment) (Jersey) Law	2005
63.	Children (Regulation of Employment) (Jersey) Order	2011

Doc No	Document Description	Date
64.	Adoption (Amendment No.3) Rules	2012
65.	Children (Amendment No.2) Rules	2013
66.	Adoption (Amendment No.6) (Jersey) Law	2013

Appendix II

Policy Committee Presidents 1973 - 2005
Chief Ministers of Jersey 2005 - present

Policy Advisory Committee (1973 - 1987)

Prior to the establishment of the Policy and Resources Committee, the closest that the States of Jersey had to a "senior" committee was the Policy Advisory Committee (PAC), which was a non-executive Committee established in 1973. PAC's function was primarily to bring forward a five year plan particularly relating to economic policy, but PAC's purpose was also to co-ordinate policy objectives that were cross-committee. The Committee continued to meet until 1987. Attached is P20/1973 which provides background to the establishment of the Policy Advisory Committee. The Presidents were -

- Senator C Le Marquand (Mar 1973 - Dec 1978)
- Deputy Sir R Marett K.C.M.G., O.B.E. (Dec 1978 - Nov 1981)
- Senator J Le Marquand (Nov 1981 - Dec 1981)
- Senator P F Horsfall (Dec 1981 -Dec 1984)
- Senator R Vibert (Dec 1984 - Dec 1987)

When new Committees were elected in December 1987, the election of the President and members of the Policy Advisory Committee were deferred and the Policy Advisory Committee was never re-constituted. The Policy and Resources Committee came into being in 1989.

Policy and Resources Committee (1989 - 2005)

The Policy and Resources Committee was set up in 1989. Its Presidents were as follows:

- Senator R.R. Jeune (Appointed 07.02.89)
- Senator P.F. Horsfall (Appointed 17.12.96)
- Senator F.H. Walker (Appointed 12.12.02)

Chief Minister's Office (2005 to present)

The Chief Minister's Office was set up in 2005, following the move to ministerial government following the machinery of government reforms. Chief Ministers to date have been as follows:

- Senator F.H. Walker (Appointed 05.12.05)
- Senator T.A. Le Sueur (Appointed (08.12.08)
- Senator I.J. Gorst (Appointed 14.11.11)

Appendix III - Bailiffs of Jersey

Les Baillis de de Jersey		
1	1277-90	Messire Philippe Levesque
2	1290-94	Pierre d'Arcis
3	1294-99	Jean de Carteret
4	1299-1309	Philippe Levesque
5	1309-1331	*les Jure-Justiciers suivants furent Baillis à tour de role* -
		Nicolas Hasteyn; Henri de St. Martin;
		Guillaume Longynnour; Pierre Hugon;
		Lucas de Espyard; Pierre de la Haye;
		Philippe de Vincheleys; Guillaume Brasdefer;
		Mathieu Le Loreour; Geoffroi de la Hougue;
		Philippe Levesque; Guillaume le Petit;
6	1332	Raoul Tourgis
7	1348	Guillaume Hastein
8	1357	Raoul Lempriere
9	1367-8	Richard de St. Martin
10	1368-70	Richard le Petit
11	1370	Jean de St. Martin
12	1373	Thomas Brasdefer
13	1373-4	Jean de St. Martin
14	1378-91	Thomas Brasdefer
15	1386-93	Thomas de Bethom
16	1395-1401	Geoffroi Brasdefer
17	1402-3	Colin le Petit
18	1405-6	Guillaume de Lecq
19	1406-25	Thomas Dunyer
20	1432-33	Messire John Bernard
21	1435	Thomas de la Cour
22	1434-6	Jean Lempriere
23	1436-42	Messire John Bernard
24	1439	Jean Lempriere
25	1444-46	Jean Payn

26	1446-51	Regnauld de Carteret
27	1452-6	Jean Poingdestre
28	1459-62)	Nicolas Morin
	1464-67)	
29	1467-76	Jean Poingdestre
30	1477	Nicolas Morin
31	1479-85	Guillaume Hareby
32	1486-93	Clement Le Hardy
33	1494	Jean Nicolle
34	1494-1513	Thomas Lempriere
35	1513-23	Helier de Carteret
36	1524	Helier de la Rocque
37	1528	Jasper Penn
38	1529-61	Helier de Carteret
39	1561-64	Hostes Nicolle
40	1566-83	Jean Dumaresq
41	1583-86	George Paulett
42	1586-87	Jean Dumaresq
43	1587-91	George Paulett
44	1591-95	Jean Dumaresq
45	1595-1614	George Paulett
46	1615-21	Jean Herault
47	1622-24	Messire William Parkhurst
48	1624-26	Jean Herault
49	1626-43	Messire Philippe de Carteret
50	1643	Michel Lempriere
51	1643-51	Messire George de Carteret
52	1651-60	Michel Lempriere
53	1660-61	Messire George de Carteret (Baronnet)
54	1661-62	Messire Philippe de Carteret
55	1662-65	Philippe de Carteret
56	1665-82	Messire Edouard de Carteret
57	1682-93	Messire Philippe de Carteret (Baronnet)

58	1694-1703	L'Honorable Edouard de Carteret
59	1703-15	Messire Charles de Carteret (Baronnet)
60	1715-63	John, Lord Carteret
61	1763-76	Robert, Lord Carteret
62	1776-1826	Henry Frederick, Lord Carteret
63	1826-31	Messire Thomas Le Breton
64	1831-48	Messire Jean de Veulle
65	1848-57	Messire Thomas Le Breton
66	1858-80	Jean Hammond
67	1880-84	Messire Robert Pipon Marett
68	1884-99	Messire George Clement Bertram
69	1899-1931	Messire William Henry Venables Vernon, KBE
70	1931-35	Charles Edward Malet de Carteret
71	1935-61	Lord Coutanche
72	1962	Cecile Stanley Harrison, CMG, OBE (died 1962)
73	1962-74	Messire Robert Hugh Le Masurier (died 1996)
74	1974-85	Messire Herbert Frank Cobbold Ereaut (died 1998)
75	1986-95	Peter Leslie Crill, KBE (died 3rd October 2005)
76	1995- 2009	Messire Philip Martin Bailhache
77	2009 -	Michael Cameron St John Birt

Depuis 1277 les fonctions de Gardien et de Bailli devenaient distinctes, et qu'on nommait deux Baillis l'un pour Jersey et l'autre pour Guernsey.

APPENDIX 8

Documents on Oversight and Operation of

Children's Services

1945–1959

Document description	Page(s)	Reference	Date
Education Committee Memorandum with regard to child welfare	12	WD005364	29.05.58
Children's Section 1st annual report	4	EE000055	31.12.59

1960–1970

Document description	Page(s)	Reference	Date
Children's Officer Patricia Thornton paper on new legislation in Jersey to follow UK legislation	13	EE000174	30.05.60
Children's Section annual report 1960	6	EE000052	31.12.60
Proposal for States to take on Jersey Female Orphans Home	3	EE000173	29.03.61
Association of CCOs' Memorandum on Young People in Care – suggests transition from children's homes to foster homes or lodgings	114	WD005369	30.06.61
Children's Section annual report 1961	5	EE000057	31.12.61
Children's Section annual report 1962	8	EE000058	31.12.62
Jersey Evening Post letter from George Maggs about the retirement of Mr Mallinson. Notes that "*at the present time there is a general cry of the Child Care service that competent staff of the right type for residential establishments are very difficult to obtain*"	157	WD005366	26.03.63
Children's Section annual report 1963	13	EE000059	31.12.63
Education Committee report on need for nursery at HDLG – mixing of children not harmful and is sometimes positively beneficial to more disturbed children	772	WD006912	27.10.64
Children's Section annual report 1964	16	EE000060	31.12.64
Home Office report on Children's Services	9	WD004627	24.03.65

Education Committee meeting – concluded that HDLG not to be used as a special reception centre	142	WD006911	05.07.65
Children's Section annual report 1965	14	EE000061	31.12.65
President of the Education Committee (Senator John Le Marquand) statement about refusal to appoint unmarried mother as Houseparent at HDLG and setting out how it sees its responsibilities to children in care	190–194	WD006910	28.11.66
Children's Section annual report 1966	6	EE000062	31.12.66
Children's Section annual report 1967	14	EE000063	31.12.67
Home Office to Jersey Solicitor General the effect in Jersey of the abolition of approved schools in UK– copy of UK command paper on "Children in Trouble" attached	25	EE000193	11.07.68
Children's Section annual report 1968	14	EE000064	31.12.68
Letter from Colin Tilbrook to Patricia Thornton regarding the excessive number of children causing "considerable strain" on staff. Letter read out at Education Committee meeting	415–416	WD008620	28.01.69
Colin Tilbrook and Patricia Thornton plan for re-organisation of HDLG: "*In the interests of good child care and to minimize the friction between staff and children it is essential to separate these children into three groups…. The possibility that the existing detention rooms will prove insufficient should be faced."*	87–95	WD005367	01.09.69
Memo from Patricia Thornton re extent of inspection, changes in Education Committee status and new powers in relation to children	142	WD006909	01.02.70
New system of filing – change from individual files to family files	266	WD008615	03.04.70
Home Office Inspection Report of the work of the Jersey Children's Department	10	WD006194	17.08.70
Home Office Inspectors before Education Committee – discussion of report	67–69	WD006906	03.09.70
Home Office record of meeting with Education committee following report – acceptance of recommendations – request	95–96	WD006908	30.09.70

that States continue to be given informal guidance			
Establishment Committee – rejecting Home Office proposal that there should be two new appointments of CCO and view that SCCO should have authority to review staffing on the basis that this would be "*an open invitation to increase staff without limitation"*	51	WD006907	02.12.70
Establishment Committee note – accept Education Committee's suggestion of trainee CCO being seconded on full salary for a period of training in the UK	49–50	WD006905	02.12.70
Memo from Patricia Thornton on the consequences of Children and Young Persons Act 1969 in the UK: "*As neither Jersey or Guernsey are local authorities I can understand that it may be necessary if a child is to be accommodated in a Community Home for him to be deemed to be in the core of an English local authority. I would, however, feel it very important that the insular authorities should not lose their parental role and I feel that they should be in a position to make policy decisions about the child. As is stated in the Home Office letter to the Attorney General it is envisaged that administratively the insular authorities should retain financial responsibility for the child and, if the changes to the Law as suggested by the Law Draftsman are accepted, this would be laid down in Article 35, Paragraph 2, of … If, therefore, the Education Committee of the States of Jersey is financially responsible for the child, it would seem that its own Officers should be able to discuss policy decisions with whichever local authority in. whose care the Jersey child is placed."*	97–98	WD005368	11.12.70

1971–1980

Document description	Page(s)	Reference	Date
Letter from Colin Tilbrook to Patricia Thornton regarding lack of staff at HDLG – notes that: "*Overcrowding forces regimentation, blunts the sensibilities and restricts individual freedom.*"	93–94	WD008614	26.04.71
Home Office meeting re changes in law – notes no legal power for Jersey to place children in UK: "*Jersey was not seeking an easy way of disposing of their difficult children*" – concluded that Channel Island children have to be included in a regional plan	79	WD006971	02.08.71
Education Committee: will provide tutor for in-service training for child care staff but Children's Officer should also personally undertake an appreciable part of the training	35	WD006964	12.08.71
In-service training in general child care matters to be provided by North-West Polytechnic (London) during 1972	81	WD008613	05.10.71
Home Office comment on the vacuum in leadership of Jersey's Children's Section and consequences for running of the section	52	WD006970	05.05.72
Charles Smith paper on transferring difficult children to Community Homes in the UK – recommends Education Committee setting up an establishment to cater for the needs of more difficult working boys and girls who would otherwise need to be accommodated in mainland establishments	53–54	WD006973	04.08.72
Establishment of Children's Policy Review Committee	19	WD006962	19.09.72
Note re relationship between Jersey and UK local authorities in wake of no classifying school being available – these would assess individuals as to the most appropriate Approved School in which to place child. Noted that Approved Schools being replaced by	43	WD006969	01.05.73

Community Homes with education			
Memo from UK Social Worker noting loss of classifying facility in UK for Jersey and explaining how Jersey are to approach UK authorities	38	WD006968	05.06.73
Review of Home Office involvement in Jersey highlighting particular differences and consequences for planning and policy	27–30	WD006972	01.07.73
Memo from Charles Smith to all staff, attaching a form for use with all Non-Accidental Injury enquiries – to be completed as part of standard procedure by the CCO	341–342	WD006698	01.08.73
Establishment Committee initial decision that it is not necessary to recruit fully a qualified candidate with professional expertise as CCO and should recruit locally instead. Senator Jeune (President of the Education Committee) then set out the need for a qualified and experienced CCO and said that there was no local candidate suitable. This was accepted by the Establishment Committee	355–356	WD006966	15.08.73
Report of a study group in UK on Non-Accidental Injury to Children held in May 1973 sent to Jersey	285–296	WD007019	18.10.73
Meeting re Superintendent and Matron (WN715 and WN870) resigning – notes what they think should change at HDLG	173–174	WD006975	16.11.73
Charles Smith report on HDLG and its purpose and restructuring in wake of 1970 Home Office report	166–168	WD006195 WD006974	22.11.73
Memo from Jim Thomson (SCCO) to all child care staff – opening a master file on Non-Accidental Injury and asks all referrals and reports to be passed to him. Makes available a small notebook with "*information concerning grounds for suspicion"*	317	WD006697	11.04.74
DHSS memos on Non-Accidental Injury to Children – received in Jersey	340–345	WD006699	22.04.74
Charles Smith paper on Non-Accidental Injury	344–345	WD006700	10.12.74

WN532 report on “Proposals for reorganisation at HDLG” – concern to provide for basic needs of children at HDLG, namely: (i) Facilities for child to be treated as an individual and have some privacy; (ii) A setting which can offer security and some feeling of home and belonging; (iii) Opportunity for development of social, physical and intellectual skills [date estimated]	234–235	WD006211	01.01.75
Education Committee Act re Non-Accidental Injury: Committee of officers to review regularly the services available for the protection, care and aftercare of children likely to suffer ill treatment	308	WD005370	23.01.75
Memo showing request from Children’s Officer for copies of Home Office guidance on conduct of children’s homes at HDLG	62	WD006193	30.06.75
HDLG Rules and Regulations – including on corporal punishment, supervision, detention rooms, discipline	19	WD002600	01.07.75
Memo from WN532 (Superintendent of HDLG) to Charles Smith on the problems of mixing children at HDLG and shortage of staff	42	WD002603	24.09.75
Education Committee decision to maintain HDLG as remand centre and provide for five children on remand	54	WD006976	13.11.75
Memo from WN532 to Charles Smith on the virtues of HDLG over Family Group Homes	15	WD006648	21.10.76
Education Committee minutes – notes policy of setting up liaison with areas of children in care and in report on HDLG that problems previously identified remain	30	WD006978	18.12.78
Report by the Children’s Officer on the staffing of the Children’s Service	3	WD006963	08.01.79
Children’s Officer proposals for change at HDLG looking at its purpose	141–142	WD006979	08.02.79
Education Committee minutes approving appointment of additional child care staff on the basis of *“a very large increase in*	38	WD006965	21.02.79

the workload of the department"			
Education Committee debate about the allocation of CCOs to children at Les Chênes – should it be just one CCO or existing CCO of each child?	15	WD006960	22.08.79
Working Group re foster children recommend that the Children (Jersey) Law 1969 be amended to enable the Education Committee to make Orders in respect of foster children. Given the delays anticipated in the bringing into force of an amendment (it is unclear whether this ever happened), the Committee agreed that foster parents and natural parents of foster children should be expected to sign an undertaking to ensure the proper care of the foster child in the meantime	18	WD006961	19.09.79
Note that Jersey has no legislation on Island relating to child employment – Committee seeking views	11	WD005374	01.10.79
Education Committee: HDLG to be retained as a remand centre should at any stage Les Chênes be full	107	WD006977	31.10.79
Duties of Child Care staff set out in order of priority, including: *"1(a) Investigating reports of child abuse (physical, emotional, mental or sexual) … 4. Supervision of all children in the care of the Education Committee*". Noted that *"the concept of priority used here is one of time not the importance of the work to be done"*	40	WD005430	02.11.79
Duties of Child Care Staff	73	WD006712	10.12.79
Critique by Charles Smith of Thomson's paper	100–101	WD006983	13.01.80
Thomson paper on HDLG – suggests that it is dysfunctional and suggests role for Education Committee to play	102–107	WD006984	25.01.80
Charles Smith to Mr Pilling – wanting to look at phasing out large children's homes	119	WD006986	27.02.80
Education Committee: discontinuing use of HDLG as remand centre	109	WD006985	19.03.80

Pilling – report on HDLG and Les Chênes – recommends an appointment of a Children's Ombudsman	38–41	WD006980 WD006196	01.05.80
Pilling report presented to Education Committee	80–86	WD006982	01.05.80
Thomson seeking endorsement of Committee for rules relating to use of secure room and attaching draft guidelines	75–76	WD006981	12.05.80
Response of John Rodhouse to Thomson paper "A Report for the Eighties"	69	WD005371	13.05.80
Thomson " A Report for the Eighties" – vision for HDLG		WD006984	17.09.80

1981–1990

Document description	Pages	Reference	Date
Lambert and Wilkinson Report		WD007382	01.04.81
Committee summarise major points of Lambert and Wilkinson Report that need to be considered and agree to set up working party	16-17	WD005378	16.09.81
Education Committee consideration of reducing institutional care resource and increasing preventative care as recommended by Lambert and Wilkinson	21	WD007007	28.10.81
Note of the Children's Sub-Committee proposing as policy the recommendations in Lambert and Wilkinson. Records consideration of a procedure for ensuring liaison between voluntary and statutory bodies that would make use of existing organisations rather than creating a new one.	5	WD006987	01.02.82
Children's Sub-Committee decision to adopt policy to phase out HDLG and have smaller units – "the smaller the better". Papers presented by Skinner and others on proposals	16–22	WD006988	10.03.82
Papers presented on the re-organisation of HDLG	24–26	WD007013	17.08.82
Committee approving DHSS proposals for HDLG – phase 1 and phase 2 plans	20–21	WD006991	01.09.82
Children's Sub-Committee recognition of need for training across the board	80–81	WD005372	23.09.82
Education Committee setting out DHSS proposals it would adopt	6	WD006992	18.01.83

Paper on staff in small children's homes – "*Aims and Objectives: Staff will work as a team to create, as far as possible, a family atmosphere where children of all ages can develop and grow through stable and supportive relationships formed within the home. This new venture in smaller units will give staff the opportunity to work more closely with the children and thus help them to develop their social skills and encourage them to undertake a wide range of activities, both within the home and within the wider community. It is recognised that many of the children cared for will be to some degree disturbed and at times difficult to control or to understand, and in order to assist staff in this task, suitable training courses will be set up."*	4	WD007000	18.01.83
Second paper on role of staff in small children's homes	6	WD007001	31.01.83
Letter from Director of Education to Treasurer of the States setting out policy rationale for closure of HDLG	229–230	WD007015	22.03.83
Proposition paper lodged in States for phasing out of HDLG – following Lambert and Wilkinson recommendation	58–61	WD007012	29.05.83
Extract from paper prepared by Charles Smith: *"The Committee believes that wherever possible a child in its care should receive an upbringing similar to that which a child in a normal family would have. He should live in a house as normal as possible in a normal street together with normal families. In this way he can face the realities of life in the community and learn to deal with them."*	176	WD007014	12.07.83
Children's Sub-Committee agree setting up two smaller homes in wake of HDLG closing	121–122	WD005381	12.10.83
Report on three-month period of secondment within the Children's Office for Head Teacher – his brief was to look at the Child Care Service from a parental point of view, liaison between primary schools and the Children's Office and the effect of being in care on the educational development of a 7- to 11-year-	14	WD006512	01.01.84

old child.			
Paper by Children's Officer on number of beds needed for residential care	12–13	WD007005	17.01.84
Paper by Terry Strettle on approach to existing and future residential care	45–47	WD006989	22.03.84
Education Committee purchase and take over La Preference	9	WD006993	08.05.84
Training by National Children's Home – basic learning module with 30 staff participating	83	WD007002	07.11.84
"A future needs discussion paper" by Terry Strettle	86	WD007003	07.11.84
"An NCH children's home in Jersey" by Terry Strettle	91	WD007004	08.11.84
Report by Education Committee on future residential provision for children in care	197–198	WD007016	31.01.86
£200,000 allocated by Finance and Economics Committee for cost of new home or two purpose-built homes	100–101	WD006999	17.02.86
Recommendation to improve provision of family aides as means of preventing children coming into residential care	7	WD005379	11.06.86
Decision to promote Child Line in the Island – *"a welcome approach towards a problem that was becoming increasing prevalent on the Island"*	16–17	WD005373	11.09.86
Promotion of Childline – "*Within Jersey the Children's Office has for some time, been promoting child protection in relation to the whole area of child abuse and in particular of sexual abuse. This work is continuing."*	8	WD005428	07.11.86
Anton Skinner paper on responsibility towards homeless teenagers (those aged 15–17)	73–74	WD007010	24.03.87
States of Jersey Education Committee – Child Abuse/Non-accidental injury – agreed code of practice	114-17	WD006302	18.08.87
Education Committee review consequences of 'policy' decision to close HDLG	2	WD006994	26.08.87
Provision for young single-parent mothers – working party set up	100	WD007008	30.08.87
Danny Wherry paper for Children's Sub-Committee on the employment of children	7–13	WD007009	30.09.87
Children's Sub-Committee re-structure fieldwork section set up hostel for homeless	4	WD005375	01.02.88

teenagers, using funds set aside for second children's home			
Paper on "Sexual abuse of children" for teachers	97–98	WD006290	01.03.88
Anton Skinner memo on local child sexual abuse procedure and situation – reference to training in 1987. Context is abuse of children within the home, with reference to Cleveland	77–79	WD007011	11.07.88
Anton Skinner to Probation Service – guidelines on child abuse procedures: "*The draft guidelines enclosed reflect quite closely the guide-lines produced by most U.K. authorities to promote a better spirit of co-operation between agencies in order to produce an effective multi-disciplinary approach to the problems of child abuse. The core of the multi-disciplinary approach is or course the sharing of know ledge and the placing of the child's safety above that of all other professional considerations."*	67–68	WD006997	24.10.88
Children's Sub-Committee received report, noting *"With regard to the matter of sexual abuse of children, the Children's Officer mentioned that not all prosecutions in respect of child abuse were carried through as it was not possible to prosecute on the uncorroborated evidence of a child. However, the Department was constantly vigilant where child abuse was suspected and was not precluded from taking 'Care' proceedings, should it be deemed necessary or desirable. The Sub-Committee also noted proposals to develop a three-year training programme for residential workers."*	3	WD005376	01.02.89
Children's Sub-Committee minutes: *"The Sub-Committee noted that the Attorney General was concerned that local Child Care Legislation be updated to correspond with recent changes made in the United Kingdom, accordingly, the Children's Officer and Crown Advocate S. Nicolle had begun preparing a brief on proposed legislation revisions for the consideration of the Education Committee.*	9	WD005377	01.08.89

The first section of proposed changes would be submitted to the Education Committee on 4th October, and would concern the issues of adoption, fostering and custodianship."			
Concern over need for legislation re employment of children – noted that it is the Education Committee's responsibility in ensuring that the appropriate legislation was enacted to protect children.	8	WD006995	18.10.89
Children's Sub-Committee notes the closure of Clos de Sables *"in view of recent events"* and the consequences for provision of placements	10	WD005380	15.11.89
Child Abuse: joint investigative team: *"The Sub-Committee noted that discussions had been held with interested bodies regarding the serious increase in the referrals of alleged child sexual abuse. At the meeting, it had been agreed that CCOs would be invited to assist in all cases of assault or abuse of children including assaults by persons outside the family circle where care and protection issues were not involved. This would increase further the workload of the Department but it was felt that this was a high priority area. The Children's Officer noted a suggestion from a member regarding the introduction of a 'Childline' service and having agreed that the anonymity that such a service could provide would be valuable, undertook to investigate the proposal."*	13	WD007006	27.11.89

1991–2000

Document description	Page(s)	Reference	Date
UK Children Act 1989 Guidance and regulations – Vol. 4: Residential Care	1–196	EE000146	01.01.91
The Pindown experience and the protection of children – report into the running of a children's home by Frank Beck – prompted the UK Government to do review of residential child care commissioned Sir William Utting – "Children in the Public Care"	1–312	EE000131	01.01.91

Education Committee note need to change Jersey child law in line with the Children Act 1989 in England and set out proposed changes	4	WD005205	27.03.91
Utting Report – “Children in the Public Care”	1–80	EE000143	01.08.91
UK Government circular to accompany release of Utting Report as well as introduction of Children Act 1989 “Findings” note need for inspection and training	1–4	EE000102	20.08.91
Education Committee discussion re future planning and personnel needs of Children’s Services	7–8	WD005206	09.10.91
Les Chênes policy for learning and teaching	25–27	WD005202	23.07.92
Education Committee note that increased awareness of public is accounting for increased number of child abuse referrals	2	WD005207	27.01.93
Choosing with Care – UK Government report on recruitment, development and management of staff in children’s homes – see recommendations at end of report [Date estimated]	268	EE000144	01.03.93
Education Committee receives year plan for Children’s Services presented by Anton Skinner and Brenda Chappell	3	WD005208	10.03.93
Mario Lundy paper on the implications of extending the age of remands to Les Chênes to 16+	14–15	WD005203	03.05.93
Letter from Anton Skinner to child formerly in care. Notes that her case file was destroyed last year "*along with all child in care files of people who had been out of care for a period of ten years following their 20th birthday*"	1–2	WD009336	09.09.94
Education Committee *“noted that in 1993 the Child Protection Team dealt*	6	WD005209	18.05.94

with 109 referrals Annual relating to the possible sexual or physical abuse of children. The Team had noted that the level of cases now reflected in the United Kingdom's which lead the Team to believe that they were aware of and dealing with the large majority of cases that occurred in the Island. There had been a general raising of awareness in the Island, referrals came from a wide variety of sources and this was a reflection of the confidence in the service that was provided."			
Advice that wholesale new law should be brought in to match 1989 Act – working group set up. Also notes: *"The Committee received a report dated 22nd February 1994, from the Children's Officer in relation to the Admission to Care Policy. The Committee noted that the Service had steadily reduced the number of children coming into care of the State during recent years, and had been facilitated by the introduction of community based preventative resources and strategies. However, despite this trend the Island had a higher child in care population than most other districts of similar size in the United Kingdom. The Committee noted the criteria for admission which in all cases the safety and welfare of the child would be considered paramount, but that all steps could be taken to preserve the authority and obligations of the parent as the primary carer and to make clear those responsibilities to the parent. The Committee endorsed the Policy."*	7	WD005210	18.05.94
Note of receipt of report about creation of Area Child Protection	20	WD005211	09.11.94

Committee – without it there was day-to-day interagency work, but no permanent forum for development of interagency policy and co-operation			
Proposals for new children law – working party recommending creation of a Family Court Division of Royal Court	4–5	WD005212	22.02.95
Extracts from presentation on "Planning services for children and families"	2–9; 13–15; 29	WD005234 WD005235 WD005233	20.09.95
Consideration of proposed change of age of majority from 20 to 18 – Education Committee advised that, from perspective of Children's Service, no reason why age of majority should not be lowered, but should take into account possible impact on Housing Regulations. Also notes decision to appoint as permanent post a child and adolescent psychiatrist in the Island	3–4	WD005213	31.10.95
Extracts from strategy report on children and families, includes reference to the Strategic Policy Review "2000 and Beyond". Notes strategy to focus on prevention and to keep children in their families within the community	94–100	WD005236	15.11.95
Heathfield policy and objectives – notes no corporal punishment and no locking of children in rooms. [Date estimated]	2–7	WD004658	01.01.96
Utting Report: "People Like Us" – UK Government report reviewing safeguards for children living away from home	1–240	EE000145	01.01.97
Extract from Educational Handbook: *"corporal punishment is not to be administered in schools under Education Committee Administration"*	35	WD005230	01.07.97
UK Government publication – "Working together to safeguard	1–128	EE000134	01.01.99

children" primarily aimed at children in the home but section on children living away from home			
Education Committee received Steven Sharp to discuss his report on Victoria College	1–3	WD008550	23.06.99
Steven Sharp Report – Inquiry on behalf of the Governing Body of Victoria College and the Education Committee. Included term of reference about the "*appropriateness of the policy, advice and procedures provided by the Education Department in respect of Child Protection issues*".	1–42	GD000018	01.07.99
Education Committee notes support for age of majority change from 20 to 18 – department to retain a discretion to provide support to those between 18 and 20 in care	9	WD005214	04.08.99
UK Protection of Children Bill discussed following report by Anton Skinner – note that it is designed to offer greater protection to children from individuals deemed to be a risk to their welfare – recommended that there should be a local equivalent in Jersey	3–4	WD005215	05.04.00
Child Protection Guidelines approved by the Jersey Child Protection Committee [Date estimated]	1–33	WD005237	31.12.00

2001–2015

Document description	**Page(s)**	**Reference**	**Date**
HSS Committee discussion regarding proposed Children (Jersey) Law 2002 reflecting Children Act 1989 re children at risk, right to administer punishment, right of child to take part in proceedings in which the child is concerned, outlawing use of corporal punishment except by parents or close family	4–5	WD005216	23.07.01

First Bull Report – Review of principles, procedures and practices at Les Chênes Residential School 2001	1–28	WD004270	01.08.01
Discussion re "reasonable chastisement" and outlawing use of implements as a means of administering chastisement	7	WD005217	05.09.01
HSS Committee consider report on developing strategy for the care of younger children – aimed at creating family based alternatives [to residential care] including fostering and adoption	15	WD005218	07.11.01
Post of child protection training co-ordinator created	4	WD005221	06.02.02
Director of Education letter to Director of Home Affairs regarding options for Les Chênes' future – notes with regret that Les Chênes to continue to take children on remand	27–28	WD005204	05.07.02
Memo to all staff at Les Chênes – notes that new policies/procedures left in staff pigeon holes.	5	WD008579	01.08.02
Response to Bull Report – noted that she had produced an ambitious model for future management and delivery of services, achieved through the creation of a Children's Council	8–9	WD005223	06.11.02
Second Bull Report – Review of residential care homes and children with SEBD		WD007383	01.12.02
Committee of inquiry into Honorary Police elections procedures – report 2002		WD005195	03.12.02
HSS Committee meeting re Brig-y-Don *"advised that the traditional role of the Home was no longer consistent with modem practice in child care in the United Kingdom, which had developed a comprehensive fostering service to place young children in a family environment"*	11	WD005222	06.12.02

Letters from Tom McKeon to Anton Skinner and Brian Heath regarding the formation of residential placement panel from January 2003	1–3	WD009147	09.12.02
Tony Le Sueur Report on housing issues affecting children in care	6–7	WD008733	01.03.03
Discussion and response to Bull Report – includes exchanges with Dr Bull, complaints about report and implementation by Marnie Baudains. Dr Bull notes that: *"This review was the first of its kind in Jersey. Consequently, there was no 'history' for the Island in terms of benchmarking or procedures for auditing, etc. Thus it was for the whole Island to determine the outcome to be achieved from the report, based on a balance of opinion. It was emphasised that, although the report had undoubtedly come as a shock to Jersey, it was not to be seen as a measure of any failure on the part of the authorities, nor was it intended that any blame should be attached to any individual or group of individuals.* *Dr Bull indicated that the services provided in Jersey were comparable to many United Kingdom local authorities … "*	2–12	WD005224	05.03.03
Act of Education Committee – expresses particular concern at the resource implications of effecting the necessary changes proposed by Dr Bull	22–24	WD008548	05.03.03
States Report – severe emotional and behavioural difficulties review 2002 – discusses Bull recommendations		WD005242	22.07.03
Letter from W Hurford to Home Affairs Committee and HSS Committee Presidents re changes	1–2	WD009145	03.09.03

from Les Chênes to Greenfields – notes care staff in place from 01.09.03 and renamed Greenfields from 03.09.03.			
Governance of Greenfields – model of governance to reflect the change in need from Les Chênes to Greenfields in light of Bull Report – Board of Visitors to replace Governors.	13–15	WD004037	03.02.04
HSS Committee meeting – noted that despite being contrary to recommendation of Bull Report *"in the short term the facilities at Greenfields should be utilised to curb the current overcrowding"* in the other homes.	3	WD004128	03.03.04
Children's Executive Progress Report 2005	18–24	WD007018	16.04.04
Establishment of a Children's Executive	14	WD005225	13.10.04
Minutes of Young Persons Meeting – forum where residents could raise concerns or anything they were unhappy with at Greenfields	2–8	WD008589	21.02.05
Memo – staff training organised for residential workers at Greenfields to cover changes due to introduction of Children (Jersey) Law 2002	366	WD008583	23.02.05
ESCD Safeguarding Children and Staff Guidelines	14–28	WD005239	01.03.05
Approach to SEBD by the HSS Committee	3–4	WD005227	04.03.05
Phil Dennett report for Children's Executive notes that residential service budgets under "severe pressure"	34	WD008604	01.04.05
Proposal for management of young people returned from absconding from residential care	1–3	WD009345	05.04.05
Minutes/reports from June/July 2005 expressing re budget savings further need for savings and cultural differences between HSS and ESC in	44–54	WD008608	05.06.05

relation to fiscal matters.			
Delay in implementing Children (Jersey) Law 2002 considered "unacceptable" by the HSS Committee	13–15	WD005228	04.07.05
"The Committee received an oral report from the President concerning the need to constantly up-date child protection legislation in order to achieve the highest standards of child protection. It was noted that practitioners had publicly expressed an opinion that the recently introduced Children (Jersey) Law 2005 might already be out of date in some respects. It was further noted that a review of present laws and policy practices needed to be undertaken in the light of the findings and recommendations of the Bichard Enquiry into the Soham murders."	17	WD005226	05.08.05
Update by Phil Dennett – note budget for training reduced for 2006 to make "efficiency saving" in October 2005	62	WD008605	24.10.05
Children's Executive Minutes – noting confusion over structure of Children's Executive and "*issues of who is responsible for who*"	68	WD008606	26.10.05
HSS Committee discussion about implementing checks on recruitment under the UK Bichard recommendations	20–21	WD005229	04.11.05
Extracts from Audit Report which suggest there is confusion over who is Corporate Parent that Children's Executive should report to and confusion over departmental responsibility	81–82	WD008601	04.11.05
Children's Executive Strategic Plan 2006–2010	140–144	WD008602	01.01.06
Report by Phil Dennett notes financial pressures easing	92	WD008607	26.01.06
Email chain noting that SOJP not	54–55	WD008632	10.08.06

allowed to pass case conference minutes to legal advisers without permission of Tony Le Sueur			
Governance and Management Arrangements for the Children's Executive	1–10	WD008738	13.09.06
Planning Workshop – year plan including discussion of governance arrangements, review of Bull recommendations, future developments	146–148	WD008609	13.09.06
Advice from the Attorney General on access to criminal records for Jersey employers	1–6	WD009313	23.10.06
Example minutes of meeting between Children's Executive and Corporate Parent	190–191	WD008610	10.11.06
Table setting out complaints received by Children's Executive/Children's Services and how these were dealt with including allegations/complaints against members of staff in children's homes	343–344	WD008611	25.03.07
Children's Executive Minutes note that growth bids submitted through HSS in 2006 and 2007 all unsuccessful	215	WD008603	10.05.07
Programme setting out visits of Assistant HSS Minister Jim Perchard	2–4	WD008744	24.10.07
Template/Guidance for assessment of child welfare/key outcomes at Greenfields	54–57	WD008584	25.10.07
Meeting of Children's Executive – notes need to prepare to respond to allegations re use of secure unit	1	WD009188	13.12.07
Andrew Williamson Report	1–31	WD006408	01.06.08
Children's Executive Progress Report 2008: Summarises the recommendations of Bull that were implemented and notes that *"it was clear that the full range of developments proposed was not going to be possible at that time*	2–18	WD008745	20.08.08

owing to financial constraints".			
Green Paper into Children – regulation of employment.		WD005197	01.10.08
Howard League for Penal Reform – a review of the Jersey youth justice system – report requested by Stuart Syvret	1–65	EE000132	01.11.08
Email chain notes that special needs service is *"woefully understaffed"* and the service is stretched beyond any possible capacity	1–5	WD009140	08.12.08
Williamson Implementation Plan	1–84	WD007433	01.01.09
Report on Staffing by Tony Le Sueur – Notes that staffing has been under considerable pressure owing to the "extreme criticisms" of former HSS Minister and subsequent abuse inquiry.	1–3	WD008752	01.04.09
Email re allegations about staff member at Les Amis – arranging meeting between HSS staff	1	WD009318	05.06.09
HSS Scrutiny Panel (Breckon) report – "Co-ordination of Services for Vulnerable Children Sub-Panel Review"		WD006407	01.07.09
States Employment Board proposal for independent investigator for suspensions of States' employees	1–2	WD009326	10.07.09
Email from Deputy Macon to Ann Pryke re behaviour of senior management and restraint of children using outdated methods.	1	WD009248	10.09.09
Response from the Minister to Breckon Report – Ann Pryke		WD009134	01.10.09
Council of Ministers discussion of Williamson Implementation: cash limits set for implementation	11–12	WD008539	15.10.09
Email from Ann Pryke (Minister for HSS) asking for her to go out with the police one weekend night to see the numbers of young people around and what other agencies are around	1	WD009155	23.10.09
Email re requirement to provide CPD	1–2	WD009247	16.03.10

and social worker's licence to practise			
Review of six Children's Services cases by Targa Partnership	1–40	WD009190	15.07.10
Role of JCPC in Williamson implementation/interaction with CPG	15–16	WD008540	15.10.10
COM discuss Children's Policy Group and Children and Young People's Plan	17–18	WD008540	11.11.10
Chart showing procedure re managing allegations/concerns against ESCD staff – Nov 2010	1	WD009215	17.11.10
Children and Young People – a strategic framework for Jersey 2011 Consultation document		WD005198	01.12.10
States' response to Howard League recommendations		WD006356	01.12.10
ESCD final internal audit report re staff vetting procedures	1–17	WD009211	06.12.10
2010 Child Protection Training Statistics [date estimated]	1–5	WD009236	31.12.10
JCPC Report to Children's Policy Group seeking change in Children's Law to bring Jersey Child Protection Framework in line with UK – Recommendation that JCPC be given statutory powers and should not fall in remit of HSS.	2–5	WD008740	01.03.11
States of Jersey Report on the needs of vulnerable young people aged 16–25	1–44	WD009382	01.04.11
Email chain – notes no reception into care without managerial approval and every effort must have been made to place with extended family/friend subject to suitability assessment	1–3	WD009230	25.05.11
Full Investigation Report into alleged misconduct re failure to escalate information of serious concerns about child in care	1–19	WD009351	16.09.11
Outcome letter from investigation into alleged misconduct. Action = development plan	1	WD009209	23.09.11

Children and Young People – A Strategic Framework for Jersey, November 2011		WD005199	02.11.11
Scottish Care Inspectorate inspection of services for looked after children	1–95	WD007039	01.01.12
Refocusing services for children – vision for 2012		WD009369	01.01.12
CPG 'Services for Children' Improvement Plan 20113 (SIP)	1–23	WD009359	16.01.12
Report on development of specialist foster care and short breaks for children with complex needs and disabilities	1–3	WD009152	22.01.12
Scottish Care Inspectorate – report of a follow-up of services for looked-after children in the states of jersey by the care inspectorate – September 2013		WD005196	07.02.12
Memo of advice from Sylvia Roberts (LOD) re broken-down adoption placement in May 2012. Notes adoptive parents' anger about lack of info prior to placement and lack of post adoption support. Urges placement off island. Mentions lack of legal requirement to undertake "disruption review" following adoption breakdown in Jersey	1–5	WD009378	05.05.12
Email chain involving Linda Dodds, Tony Le Sueur and Richard Jouault – records poor practice with regard to assessment of children. Also that "*we are currently being asked to avoid public criticism in conferences around this issue …"*	1–2	WD009255	11.05.12
Scottish Care Inspectorate makes States Members aware of responsibility re corporate parenting and child protection	12	WD008541	31.05.12
Board of Visitors' Terms of Reference	1–3	WD009315	01.06.12
Board of Visitors report for meeting of CPG	1–4	WD009237	23.07.12
CPG "Services for Children"	1–23	WD009364	27.07.12

Improvement Plan 2012–13, Quarterly Report from Quarter 2 2012 (SIP)			
Voice of the Child Audit by the JCPC		WD009239	01.08.12
Action for Children – review of services for children and young people with complex and additional needs	1–30	EE000082	01.09.12
CPG “Services for Children” Improvement Plan 2012–2013, Quarterly Report from Quarter 3 2012 (SIP)	1–32	WD009365	26.10.12
Number of children who had been adopted from care as a percentage of those who are looked after for 6 months or more – 2005–2012	1	WD009316	31.12.12
Report by Phil Dennett on creation of post of Medical Adviser for Looked After Children	1–3	WD009151	21.01.13
Leaving Care Team/16 plus – Statement of Purpose and Function	1–10	WD009224	01.02.13
CPG Discussion Paper on possibility of Children's Minister or Children's Commissioner		WD009317	01.04.13
CPG “Services for Children” Improvement Plan 2012–2013, Quarterly Report from Quarter 1 2013 (SIP)	1–35	WD009249	26.04.13
Draft HSS Report on “Outcomes for Looked After Children”	1–11	WD009144	01.05.13
Information sharing agreement – MASH – between police and States of Jersey to assist with identifying and assessing risks to children's welfare	1–19	WD009358	10.07.13
Youth Offending in Jersey – report 2013		WD005244	22.08.13
Snapshot of what development of children’s services procedures/policies in existence	2–9	WD008741	22.10.13
Meeting of SCR sub-committee – notes “*Need to consider publication issues; this should be on*	1–4	WD009170	13.12.13

Safeguarding Board's website for 12 months/possibly 6 months and see if the Press spot them. Have a Press Release ready should this happen."			
Reporting of complaints from Looked After Children – 2013	1	WD009319	31.12.13
Statistical analysis of children in care from 1862, by Tony Le Sueur	1–5	WD008732	01.01.14
Children and Young People Framework Delivery Plan	1–10	WD008731	01.03.14
Report by Tony Le Sueur on criteria used for deciding whether to conduct SCR – concludes that local guidance is deficient	2–13	WD008751	09.06.14
Safeguarding Partnership Board – annual report 2013		WD005241	08.08.14
Rapid Improvement Plan Nov 14–Mar 15	1–10	WD009150	21.11.14
JSPB minutes – Notes a "*lot of similarities between Jersey and Rotherham*" – including children's homes which are not easy to monitor by staff and targeted by perpetrators	1–3	WD009355	11.12.14
JSPB Annual Report 2014 and Priorities and Business Plan 2015	1–77	WD009132	01.02.15
Debbie Key report on "Early Help Approach" – recommendations approach. Used for when children have emerging additional needs that are unclear or broader than a service can address. Not for use when risk of significant harm.	1–9	WD009323	06.02.15
Proposal for development of a sexual assault referral centre	1–7	WD008629	01.07.15
Report to the JCPC re "arrangements for safeguarding children living away from home" – summary of recommendations	73–74	WD009206	undated

APPENDIX 9

Education and Children's Services Department and

Health and Social Services Department

Policies, Procedures and Guidance

Reference	Page(s)	Date	Content
WD001188	92	01.01.62	HDLG "Rule with regard to Corporal Punishment"
WD005826	32–33	01.01.69	Rules at HDLG re fines, children leaving
WD002534	1	28.03.69	Example showing procedure for investigation of accident suffered by child at HDLG
WD008612		01.02.71	Memo with guidance about discipline at HDLG
WD001486	1	18.10.74	HDLG detention subject to "Home Office regulations"
WD002600	3–19	01.07.75	HDLG Rules and Regulations, including punishment, record keeping and visitors
WD004279	18–21	01.08.78	Les Chênes policy on home leave
WD004280	22–29	01.08.78	Les Chênes operation of Merit Award System
WD004272	102	01.10.78	Les Chênes admissions policy
WD004281	43–45	01.11.78	Les Chênes guidance/policy for use of secure rooms
WD002605	19	10.10.79	HDLG outline of Disciplinary Code
WD005426	75–76	12.05.80	HDLG Draft guidelines on use of "detention" or "secure" rooms
WD006212	24–25	01.10.80	HDLG Rules for use of secure rooms
WD004214	6–15	01.01.86	Les Chênes admissions policy
WD006302	113–116	18.08.87	States of Jersey Education Committee – Child Abuse/Non-accidental injury – code of practice
WD004289	1–48	01.01.90	Les Chênes handbook – includes policies on secure accommodation and admissions among others

WD009137		01.06.91	"Child Protection Guidelines – Working Together – Inter agency procedures for the Protection of Children in Jersey"
WD000604	1–2	05.11.91	Residential Child Care Staff – Disciplinary Procedure
WD008546		22.02.94	Children's Services Admission to Care Policy
WD008545	174–176	13.07.94	Children's Rights and Complaints Procedure
WD009357	1–5	01.01.96	Child Protection procedures – specifically directed towards schools
WD004658	2–7	01.01.96	Heathfield Home statement, including rules on physical force [Date estimated]
WD005230	35	01.01.97	Extract from Educational Handbook – *"corporal punishment is not to be administered in schools under Education Committee Administration"*
WD005384 WD005385	67–68 96	06.04.99	Correspondence with view of HSSD that although they could not find a copy of the written policy, corporal punishment was not permitted by the Education Committee [in 1986–1990].
WD008734	1–36	01.01.00	Children's Services Policy and Procedure Manual – including procedure for managing children received into care; children missing from care; staff supervision; staff "Code of Practice"
WD009338	1–69	01.11.00	Children's Services standards for the registration and inspection of children's residential establishments in Jersey – Aviemore, Oakwell, Heathfield, La Preference, Brig-y-Don, La Chasse, St Mark's
WD005237	1–33	31.12.00	Child Protection Guidelines approved by the Jersey Child Protection Committee [Date estimated]
WD008960	1–5	01.01.01	TCI trainer manual/guidebook [Date estimated]

WD009349	1–12	12.08.02	Sexual Misconduct Policy for Children's Service
WD005289	69–75	01.01.03	Social Services Procedure for the Provision of Staff Supervision
WD009350	1–3	15.05.03	Note at a disciplinary hearing for a residential CCO that there is no disciplinary code of conduct and therefore the Civil Service Code was used in order to follow “good practice”
WD009226	1–25	07.05.03	Children’s Services Adoption Policies and Procedures
WD008728	2–4	01.04.04	Summary of Children’s Services policy development as at 2004. Lists the policies in place and the expected completion date for updates.
WD009035	1–5	01.07.04	States of Jersey Child Protection Committee Guidance into “Allegations against staff”
WD008591	56–83	01.08.05	Children’s Services Child Protection Procedures
WD009062		01.09.05	HSS Policy for Management of Serious or Untoward Incidents
WD009252	1–2	27.09.05	Heathfield “Behaviour Management Plan” – Deals with response to absconding. Notes that loss of family contact time will not be used as a sanction.
WD008634	98–99, 73–96	01.01.06	Protocol for Information Sharing
WD008602	140–144	01.01.06	Children’s Executive Strategic Plan 2006–2010
WD005767	1–42	01.01.06	Greenfields policies and procedures, including complaints, visitors, child protection
WD005765	1–2	01.01.06	Greenfields Restraint Policy [date estimated]
WD005764	1–3	01.01.06	Greenfields Policy on Restraint (part 2) [date estimated]
WD005763	1–7	01.01.06	Greenfield “Grand Prix” Policy on admissions, behaviour [date estimated]
WD009052	55–70	01.08.06	Civil Service Disciplinary Policy – applied to staff

			accused of abuse [date estimated]
WD009201	1–11	01.10.06	Policy on the use of TCI
WD009203	2–12	01.10.06	HSS policy for staff safety while working alone. NB: notes that control and restraint should not be used by staff working alone
WD009220	1–23	01.11.06	Children's Service Looked After Children Procedures
WD009330	1–2	03.11.06	ESCD Policy – Procedure for disseminating sensitive information re Child Protection
WD009148	1–23	01.09.08	Children's Service Looked After Children procedures – 2005 policy revised in 2007 and reviewed in 2008
WD009194	235–244	01.08.09	HSSD guide for users on "raising concerns/making a complaint"
WD009245	1–48	19.08.09	ESCD Child Protection Policy and Guidance – updated version of 2006 policy
WD009341	1–7	01.10.09	Formal processes for determining whether a child should be taken into care and for managing subsequent placement decisions
WD009229	1–3	01.01.10	Guide for staff at La Preference to completing incident reports [date estimated]
WD009366	1	01.01.10	Greenfields policy on what to do if there are staff shortages. Notes staff shortages are not an excuse for inadequate care [Date estimated]
WD009243	1–23	01.02.10	Children's Service Looked after Children Procedures
WD009329	1–5	01.02.10	Social Services Procedure for the provision of staff supervision
WD009251	1–4	16.06.10	La Preference "Behaviour Management" – policy includes that on physical punishment, restraint and what measures are prohibited
WD009213	1–9	05.08.10	Memorandum of Understanding for investigations into criminal conduct alleged against an employee

			of States of Jersey which might cause significant damage to the reputation of the States of Jersey
WD009018		01.09.10	HSS Policy for Management of Serious or Untoward Incidents
WD009192	215–222	01.10.10	Whistle-blowing procedure for HSSD
WD009215	1	17.11.10	Chart showing procedure re managing allegations/concerns against ESCD staff – Nov 2010
WD009244	1–162	01.02.11	JCPC Multi Agency Child Protection Procedures
WD009223	1	01.03.11	Admission policy for Brig-y-Don House [date estimated]
WD009381	1–3	01.03.11	Physical restraint policy at Brig-y-Don House
WD009340	1–6	01.03.11	Complaints and Representations Procedure at Brig-y-Don House [date estimated]
WD009164	1	01.03.11	Letter to staff about the management of concurrent internal disciplinary and criminal investigatory procedures [date estimated]
WD009253	1–5	31.03.11	Greenfields policy on physical restraint [date estimated]
WD009242	1–18	01.07.11	Multi agency organised and complex abuse procedures
WD009162	1–15	01.08.11	States of Jersey Policy on employment of people with past criminal offences
WD009193	223–234	01.10.11	HSSD Complaints procedure – guidance for staff.
WD009337	1–13	01.01.12	Procedure for assessing and approving all prospective adopters [Date estimated]
WD009339	1–7	01.01.12	Complaints and Representations Procedure for Looked After Children – other than complaints of “significant harm” [Date estimated]
WD009219	1–22	01.03.12	Children’s Services missing from care procedures [date estimated]

WD008737	2–16	01.06.12	Example “Statement of Purpose and Function” for Home – includes extracts from policies on behaviour management, abuse and the reporting of abuse, bullying/harassment, complaints and suggestions, residents’ rights, staff supervision and report
WD009154	1–45	01.08.12	ISS Independent Reviewing Officer Handbook
WD009210	1–15	01.08.12	ISS Service Specification
WD009370	1–6	01.10.12	Policy on Fostering Panel
WD009371	1–4	01.10.12	Policy on those disqualified from fostering
WD009372	1–16	01.10.12	Policy on assessment and approval of foster carers
WD009235	1–48	01.03.13	ESCD Safeguarding policies – an overview
WD009228	1–7	01.04.13	Complex case planning processes
WD009202	2–21	01.04.13	HSS policy on “Missing from Care”
WD008729	1–8	01.05.13	Example of Home ‘Statement of Purpose and Function’. Contains extracts from policies on: dealing with complaints; behaviour management; responding to abuse; control, restraint and discipline;
WD009358	1–19	10.07.13	Information sharing agreement – MASH – between police and States of Jersey to assist with identifying and assessing risks to children's welfare
WD009383	1–19	30.10.13	Safeguarding Partnership Board Policy, procedures and practice guidance on “Safeguarding Children who run away and go missing from home or care”
WD009159	1–3	01.01.14	HSS “fit person” checks guidance [Date estimated]
WD008628	1–12	01.01.14	Multi-Agency Procedures – Safeguarding children who go missing from home or care [Date estimated]

WD009309	1–26	22.01.14	Protocol for Information Exchange between States Departments
WD009373	1–4	01.02.14	Draft policy on “exemptions to a foster carer's approval”
WD009374	1–8	01.02.14	Draft policy on “Supervision and Support of Foster Carers”
WD009375	1–7	01.02.14	Draft policy on “Review of Foster Carers”
WD009376	1–11	01.02.14	Draft policy on “Allegations Against Foster Carers”
WD009377	1–4	01.02.14	Draft policy on “Employees who wish to become Foster Carers” – NB: rarely appropriate for member of staff to become foster carer for child with whom they have professional contact
WD009356	1–17	01.06.14	Multi Agency Child Death Policy
WD009312	1–23	04.11.14	Guidance for Safe Recruitment, Selection and Retention for Staff and Volunteers
WD009212	1–17	13.01.15	States of Jersey safe recruitment policy for work with vulnerable people including children

APPENDIX 10

Terms of Reference

The Committee of Inquiry ("the Committee") is asked to do the following –

1. Establish the type and nature of children's homes and fostering services in Jersey in the period under review, that is the post-war period, with a particular focus on the period after 1960. Consider (in general terms) why children were placed and maintained in these services.

2. Determine the organisation (including recruitment and supervision of staff), management, governance and culture of children's homes and any other establishments caring for children, run by the States and in other non-States run establishments providing for children where abuse has been alleged, in the period under review and consider whether these aspects of these establishments were adequate.

3. Examine the political and other oversight of children's homes and fostering services and other establishments run by the States with a particular focus on oversight by the various Education Committees between 1960 and 1995, by the various Health and Social Services Committees between 1996 and 2005, and by ministerial government from 2006 to the current day.

4. Examine the political and societal environment during the period under review and its effect on the oversight of children's homes, fostering services and other establishments run by the States, on the reporting or nonreporting of abuse within or outside such organisations, on the response to those reports of abuse by all agencies and by the public, on the eventual police and any other investigations, and on the eventual outcomes.

5. Establish a chronology of significant changes in childcare practice and policy during the period under review, with reference to Jersey and the UK in order to identify the social and professional norms under which the services in Jersey operated throughout the period under review.

6. Take into account the independent investigations and reports conducted in response to the concerns raised in 2007, and any relevant information that has come to light during the development and progression of the Redress Scheme.

7. Consider the experiences of those witnesses who suffered abuse or believe that they suffered abuse, and hear from staff who work in the services, together with any other relevant witnesses. It will be for the Committee to determine, by balancing the interests of justice and the public interest against a presumption of openness, whether, and to what extent, all or any of the evidence given to it should be given in private. The Committee, in accordance with Standing Order 147(2), will have the power to conduct hearings in private if the Chairman and members consider this to be appropriate.

8. Identify how and by what means concerns about abuse were raised and how, and to whom, they were reported. Establish whether systems existed to allow children and others to raise concerns and safeguard their well-being, whether these systems were adequate, and any failings they had.

9. Review the actions of the agencies of the government, the justice system and politicians during the period under review, in particular when concerns came to light about child abuse and establish what, if any, lessons are to be learnt.

10. Consider how the Education and Health and Social Services Departments dealt with concerns about alleged abuse, what action they took, whether these actions were in line with the policies and procedures of the day, and whether those policies and procedures were adequate.

11. Establish whether, where abuse was suspected, it was reported to the appropriate bodies, including the States of Jersey Police; what action was taken by persons or entities including the police, and whether this was in line with policies and procedures of the day and whether those policies and procedures were adequate.

12. Determine whether the concerns in 2007 was sufficient to justify the States of Jersey Police setting in train “Operation Rectangle”.

13. Establish the process by which files were submitted by the States of Jersey Police to the prosecuting authorities for consideration, and establish –

    i. Whether those responsible for deciding on which cases to prosecute took a professional approach;

    ii. Whether the process was free from political or other interference at any level.

14. Set out what lessons can be learned for the current system a residential and foster care services in Jersey and for third-party providers of services for children and young people in the Island.

15. Report on any other issues arising during the Inquiry considered to be relevant to the past safety of children in residential or foster care and other establishments run by the States, and whether these issues affect the safety of children in the future.