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.