

## Executive Summary

### Introduction

- 1.1 Our remit has been to establish what went wrong in Jersey’s child care system over many decades. That there were failings is not in dispute. Those failings impacted on children already at a disadvantage, whether through family circumstances, a crime committed against the child or even a crime committed by the child. For many children who were removed from home situations deemed harmful or unsatisfactory, the States of Jersey proved to be an ineffectual and neglectful substitute parent.
- 1.2 On 6 December 2010, Jersey’s Chief Minister made a formal apology to all those who had suffered abuse in the States’ residential care system, acknowledging that the system had failed some children in a serious way. On 6 March 2013, the States Assembly formulated the Terms of Reference for what was to become the Independent Jersey Care Inquiry. On that occasion, the Chief Minister, Senator Ian Gorst, said this:

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

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

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

- 1.4 The Inquiry sat for 149 days of hearings and consultations, allowing over 200 witnesses to give evidence directly. Additionally, the Inquiry considered the evidence of over 450 former residents of, and those otherwise connected to, Jersey's care system. The Inquiry processed and considered around 136,000 documents (a significant proportion of which amounted to many pages). We also undertook over 100 consultations and meetings with agencies and members of the public in Jersey and with child care experts. We record our appreciation of all who have assisted us, particularly witnesses who were formerly in the care of the States of Jersey, many of whom gave evidence of experiences that must have been extremely difficult to recount. Without their courage, this Inquiry would not have been able to perform its work.
- 1.5 We have conducted our work independently of the States of Jersey, of the Police, of the Judiciary, and of any other organisation or individual in Jersey or beyond. We are impartial and favour no group or individual. We have reached our conclusions on the basis of all the evidence that we have considered.
- 1.6 Arrangements for protecting the privacy of witnesses are described in the Report. Ciphers have been used for witnesses whose evidence was heard anonymously. This included former residents of care homes who wished not to have their identity in the public domain, and victims of abuse. Persons against whom allegations had been made and who met the criteria set out in the Inquiry's Protocols also were given a cipher ("WN" followed by a cipher number).

## **History and social context**

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

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

- 2.2 In fulfilling this Term of Reference and considering other aspects of our remit, including lessons to be learned for the future, we explore what is termed the “Jersey Way”. At its best, the “Jersey Way” is said to refer to the maintenance of proud and ancient traditions and the preservation of the island’s way of life. At its worst, the “Jersey Way” is said to involve the protection of powerful interests and resistance to change, even when change is patently needed.
- 2.3 The view of Graham Power, former Chief Officer, States of Jersey Police (SOJP), was that a disproportionate amount of power in Jersey was concentrated in the hands of a few people who resisted change on principle. Former Deputy Trevor Pitman described the “Jersey Way” as *“the powerful, the establishment protecting the guilty and ensuring that those who probably should be held to account will not be held to account”*. Deputy Bob Hill said there was a *“culture of fear”* in Jersey, with people afraid to come forward with information or criticisms of others who could have an influence over the informant’s job or family. He believed that this culture impacted on child abuse investigations.
- 2.4 The Howard League has described how, in Jersey, *“Powerful interlocking networks may exclude and disempower those outside of the groups and make it hard for those outside of those networks who have genuine concerns to raise them or make complaints in an effective way. This is likely to be particularly true of deprived, disadvantaged and powerless children”*.
- 2.5 We consider that an inappropriate regard for the “Jersey Way” has inhibited the prompt development of policy and legislation concerning children. Treating children in the care system as low priorities fails those children and shames the society concerned. Equally, a care system in which insufficient effort is made to prevent children from being abused, whether physically, emotionally

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

- 2.6 We have had regard to the social divisions in Jersey and their impact on child welfare. We have considered Jersey's distinctive structures and approaches to social policy. The absence of a welfare safety net until recent times, for example, meant that access to relief depended upon the personal judgement of the local Connétable. The Connétable played an important role in the child care system, including the approval of foster parents, applying for admission of a child into care, and reporting to the Attorney General if any child appeared to be in need of care, protection and control. We saw no evidence of any training or expertise being required for this role.
- 2.7 We have also noted how the shortage and cost of housing have had a marked impact on family life and wellbeing for some families, and on fostering in Jersey, with some potential candidates having insufficient space to accommodate foster children. Pressures on accommodation in Jersey have also had a detrimental effect on the ability of the relevant departments to recruit and retain suitably qualified and trained child care staff from outside the island. We have found strong ties between accommodation and child care practice. Individuals and their families were often provided with accommodation onsite (e.g. at Haut de la Garenne (HDLG)) and their presence influenced the culture of the establishment. Other child care staff had access to accommodation dependent on their employment. At times, this had an inhibiting effect on their willingness to raise concerns about systems, practices or colleagues. We concluded that at no time did the Housing Department accept or discharge the role that it had to play in the States of Jersey's responsibility as the 'corporate parent' of children in care.

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

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

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

### Residential establishments

- 3.2 Starting with Jersey Home for Boys (JHFB) and Jersey Home for Girls (JHFG), we describe the homes' operation through to their amalgamation in 1959, when the combined institution became known as Haut de la Garenne. Following the incorporation of Westaway Crèche, HDLG was providing care for up to 67 boys and girls who ranged from weeks old to school-leaving age. We discuss the routes and reasons for children coming into state care, including the significant proportion of children who were admitted at the request of a local Connétable, without any statutory order. In 1986, HDLG finally closed, its occupancy having dropped and children having transferred to La Preference and to Heathfield.
- 3.3 La Preference was originally run by the Vegetarian Society from 1951 to 1984. All children admitted in this period had to adopt a vegetarian diet and lifestyle, regardless of their preferences, and the Inquiry heard evidence of children being punished for eating meat products. There was only ever one external inspection of La Preference, in 1981. It was taken over by the States in 1984 and was used as a residential home until 2012.
- 3.4 In December 1986, Heathfield opened to provide residential care for the remaining children left in HDLG. There were a number of significant changes to the organisation and function of Heathfield following its foundation.
- 3.5 Sacré Coeur was a Roman Catholic orphanage that ran for nearly 70 years before there was any form of inspection by the state. We consider unsatisfactory the casual arrangements that allowed some children to spend their entire childhood in that institution, with no apparent statutory basis and with no social work oversight or input.
- 3.6 In the late 1960s, the States of Jersey experimented with a small number of Family Group Homes (FGHs). In each establishment, a Housemother was recruited and provided with accommodation for her family and for families of children who would otherwise be cared for in large residential homes. The

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

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

### Foster care

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

emotional cruelty and neglect at the hands of unsuitable foster carers.

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

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

#### Decisions to admit children to care and discharge from care

- 3.10 While our remit is to look at residential care, when considering admissions to care it has been essential to consider the principles, policies and professional practices that inform the decisions that led to children coming into the care system. For many decades, social work practice in Jersey has failed to develop standards and processes commonplace in other parts of the world. We heard evidence about serious case reviews (SCRs) conducted in recent years, which identified ongoing poor assessment practice and missed opportunities to remove children from harmful environments, failures to react to children's complaints and staff with insufficient skills working under inadequate management oversight in the area of child protection. Poor practice leads to poor decisions about children and their needs.
- 3.11 Although the legislative bases for taking children into care were widely drafted, we consider that some children were received into care without a

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

- 3.12 We noted, for example, that, during Mario Lundy's term of office at Les Chênes, a policy was adopted that allowed a child to be admitted for long-term stay on the imposition of a probation order with a condition of residence at Les Chênes. We found this approach to be seriously flawed and a distortion of the purpose of a probation order, which is to assist and support young people in the community. We also found that the Education Committee did not exercise proper oversight with regard to such placements.
- 3.13 It is clear to us that, in the 1940s and 1950s, there was no real expectation that a child in Jersey, once admitted into care, would ever leave the care system. No doubt for that reason, there was no specific provision in law for the return of children to their birth families, although this does appear to have happened on occasion.
- 3.14 It is clear that, at least up to the mid-1980s and the closure of HDLG, the placement of children in residential facilities reflected the availability of such places on the island and the lack of alternatives, such as preventative work or placement with foster or adoptive families, rather than the assessed needs of the children concerned. Whether those needs were best met in a residential facility does not appear to have been a consideration at this time.
- 3.15 There was no consistency in the approach taken when considering whether the child's circumstances justified removal from the family home. For example, there were cases when the justification for removal of a child from their family and placement in a care institution was that the child had "*behaviour problems*", such as being involved in "*petty pilfering*", or was said to be "*rude and cheeky*". Such a draconian intervention paid no regard to the rights and needs of the child.
- 3.16 Until the late 1980s, there was no system for providing parents with assistance in the home, which could have avoided the need for removal; a parent who sought assistance from the Parish was subject to the unregulated



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

- 3.17 We found that, in Jersey, the approach to child care has been generally reactive, with no considered criteria for admission into residential care for many decades. There was also, for decades, no adequate review of placements, and much of the time the wishes of the child were not sought. There was a pattern of maintaining children in residential homes for an excessively long period. There was no coherent model of intervention, and no consideration of what therapeutic work was necessary to enable a child to return home.
- 3.18 We considered that the mechanism for discharging a child from care was thoroughly inadequate. Although the States of Jersey had the legislative power to discharge children from care when it was in the best interests of the child, at least up to the late 1980s/early 1990s, there does not appear to have been any system for proactive consideration of this: the child was effectively abandoned in the care system. When a child left the care system in their mid-teens, they were often again abandoned without adequate aftercare to make their own way in the world. In such circumstances, young people succumbed to exploitation, addiction, crime and depression. A few who went on to build careers attributed their survival and success to fierce personal determination and often the support of a concerned adult, a teacher, child care officer or family friend.

Summary: state intervention and state indifference

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

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

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

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

- 4.1 Term of Reference 2 requires us to determine the organisation (including recruitment and supervision of staff), management, governance and culture of children's homes in which abuse has been alleged, over the relevant period, and to consider whether these aspects of these establishments were adequate. Chapter 4 of the Report sets out, in detail, key events and findings in full.
- 4.2 In this summary, we describe briefly the most notable findings in relation to each establishment. In all, we have made over 100 findings in relation to the operation of various institutions. Some findings, such as those in relation to standards of care and use of secure accommodation, are applicable to more than one home. We consider these briefly, then move on to look at individual homes.

- 4.3 We found that there has long been in Jersey an absence of political and professional will to set or monitor standards of care, including aftercare, or to prioritise resourcing the care of the children for whom the state had parental responsibility. Between the 1940s and early 1970s, the States appeared to take little responsibility for ensuring that there were adequate standards of care in voluntary homes, including homes in which it placed children. In earlier decades, there were occasional invited inspections of States' care homes by UK Home Office experts, but these had ceased by the 1970s and no form of internal inspection replaced them. For the remainder of the period in which the homes operated there were only rare external reviews. For example, in 1981 Inspectors David Lambert and Elizabeth Wilkinson, from England, carried out an inspection the findings of which we make reference to throughout our Report. Their recommendations included that HDLG be closed, that provision for residential care be re-assessed and that resources for preventative care be increased. As with later reports by Dr Kathie Bull and Andrew Williamson, significant recommendations were not implemented. We noted also that, for decades, residential staff and field social workers appeared to work in separate silos instead of combining forces and resources to secure the best outcomes for children.
- 4.4 From the perspective of many former residents, the awareness or the use of secure accommodation or detention rooms has been a significant feature of their care experience. We have made detailed findings in respect of the use of detention rooms/secure accommodation in various establishments. Throughout the period reviewed, secure rooms were not used in other Western nations, save for the most serious of circumstances, and only as a means of last resort and for the minimum necessary time. For example, by the early 1980s, the use of secure accommodation in homes in the UK was subject to strict regulation, and each confinement required the approval of a senior member of the local authority. There was daily review of the necessity for secure confinement, and regular assessment of the child by a medical practitioner. Secure rooms were never used to punish or control children. In general, we found that, in Jersey, such facilities were used routinely and

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

#### Jersey Home for Boys and Jersey Home for Girls

- 4.5 In the late 1950s, Jersey's children homes were operating under rules drafted in 1924. In this period there was no regulation of punishments in care homes. Various records from the punishment books refer to strappings and public punishment. We heard, however, many accounts of cruel and degrading punishments, such as children being humiliated and beaten with nettles for bedwetting, or being locked in confined spaces. Many examples are provided in the Report and in the brief histories of people in the care system at Appendix 2. Even by the standards of the time, the approach to punishment in Jersey homes in the 1940s and 1950s was inappropriate, and we find the management and oversight of the homes to have been deficient in this regard.
- 4.6 We considered evidence about bullying and child-on-child sexual abuse, both of which are substantiated by records in the punishment books. Other than by the use of corporal punishment, we saw no evidence of these issues being tackled. Although, in hindsight, we consider this to have been unsatisfactory, the approach taken is likely to have been in accordance with the standards of the time.
- 4.7 It would appear that qualifications or training were not a requirement for persons being recruited to senior roles at the homes, and that no training or supervision was given to persons caring for large numbers of children, many of whom had significant emotional needs, having experienced trauma, bereavement, abuse or neglect. Even though the culture of JHFB and JHFG changed over the relevant period, as staff changed, the regimes remained harsh and strictly regimented and the suffering of the children who were sent there did not diminish.

#### Sacré Coeur

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

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

- 4.9 The majority of witnesses describe a harsh and strict regime, with frequent physical, frightening or humiliating punishments for breaking rules. Some witnesses consider that the regime, while strict, was not abusive. We find, however, that the preponderance of the evidence justifies the conclusion that the regime at Sacré Coeur was abusive, with the emphasis on rigid discipline rather than on nurture. This is so even taking into account the standards of the time.
- 4.10 We found that while the industrial model of training residents of working age in factories existed elsewhere, it continued much longer in Jersey. Notably, even young children at Sacré Coeur contributed to the work and output of the Summerland garment factory.
- 4.11 Sacré Coeur was a well-known institution on the island, accommodating a large number of children who were seen selling produce and collecting money. Such an institution, and the welfare of its children, should have been of interest and concern to the public authority. It was not adequate in that, as of May 1958, there were 66 children resident at the Orphanage without any public supervision or inspection. We have seen evidence of only one visit by the Children's Officer, in 1964. We consider that the States of Jersey should have taken greater responsibility for ensuring that these children were adequately cared for. Given that the authorities had powers in this period with regard to children who were privately fostered, we do not accept that the state was powerless in relation to the large number of children admitted to the Orphanage.

#### Haut de la Garenne

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

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

#### Heathfield

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

#### La Preference

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

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

### Brig-y-Don

- 4.16 Brig-y-Don (BYD) succeeded as a voluntary children's home largely because of the leadership of Margaret Holley, who kept up with child care practice elsewhere and maintained a high staff-to-child ratio. In the late 1980s and early 1990s, the Home was at the forefront of shared care, outreach and key worker schemes, which helped to focus on the individual needs of children and promote close contact between children and their families. WN503's recruitment helped to drive progress in developing child care practice at the Home. The ethos of the Home was described as warm and friendly, and staff turnover was low. Staff received supervision and attended training sessions. Children's rights to complain were acknowledged and supported. The Brig-y-Don Committee provided proper oversight of the establishment.
- 4.17 Notwithstanding the nurturing environment, the States' practice of placing young children under four years of age in residential care at BYD up to and during the 2000s was significantly out of step with practice in other jurisdictions. We found States involvement in the governance of BYD to be adequate while it was a Voluntary Home but, once the States took over the management of the Home, it became an entirely different institution. Between 2012 and 2014, the management and organisation of the Home was not adequate. In 2013, the Board of Visitors were "*very concerned*" about the situation at the Home, noting that it had "*the character of a turbulent children's*

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

## Family Group Homes

### *General*

- 4.18 The rationale for setting up FGHs in the late 1950s/early 1960s was to move children from large institutions into smaller, more homely settings. This was an appropriate policy to have adopted. By the early 1970s, however, the concept of the FGH was being abandoned across the UK as unworkable. Jersey, however, continued to expand a model that was characterised by poor oversight and unsuitable, inadequately trained or poorly supervised staff, which led to children suffering abuse or failing to receive nurturing care.
- 4.19 We found evidence that the intended arrangements for support and oversight of FGHs were inadequate. The expectations placed on the Houseparents were too onerous and there was an inadequate system of expecting the Housefather to look after the children without being employed by, or accountable to, Children's Services. Despite Home Office recommendations in 1970, there appears to have been little professional development for staff in the FGHs. Some Children's Service staff became overly familiar with the Houseparents and failed to exercise impartial professional oversight. Visits by child care officers (CCOs) were irregular and ad hoc visits by the Children's Officer insufficient. In an island as small as Jersey, this is inexcusable and inexplicable. There was insufficient attention paid to maintaining children's links with members of their birth family. Indeed, on the evidence available to the Inquiry, in some of the FGHs, those links were positively discouraged.

### *Clos des Sables*

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



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

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

*FGH run by WN279 and WN281*

- 4.22 In line with the other FGHs, the staff and the Houseparents did not receive any training, or any guidance as to acceptable forms of discipline. The evidence we received on the culture of the Home was mixed. For at least some of the residents, there was a tense and controlling atmosphere, in which the children in care were spoken to and disciplined harshly and did not have their emotional needs looked after. WN279 said that, at the time, a group of the children were "*persistent liars*", and this sort of disdain appears to have influenced the culture of the Home. One witness referred to it as a "*reign of terror*" and the contemporaneous records suggest that the ability of the children to speak out was limited. On the other hand, other adults spoke positively about their time at the Home.
- 4.23 We consider that the oversight of the Home was largely inadequate. Although there were regular visits by CCOs nothing appears to have been done about the reports of one CCO, Ms Hogan, in 1975 that were critical of the culture of the Home. Furthermore, the allegations of physical abuse that were raised in

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

#### *Norcott Villa*

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

#### *Blanche Pierre*

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

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

- 4.27 As far back as 1987–1988, CCOs were recording Jane Maguire’s inability to cope and her resistance to outside intervention, yet nothing was done to address this. Brenda Chappell’s friendship with Jane Maguire was unprofessional in that it prevented her from undertaking proper objective scrutiny of the establishment and so failed to safeguard the residents of Blanche Pierre. Concerns raised by CCOs about the Maguires were not heeded at a higher level.
- 4.28 There is no evidence that the Home Diaries were ever inspected: had they been, the abuses perpetrated by Jane and Alan Maguire would have been identified much earlier. We find it astonishing that at Blanche Pierre such a record of flagrantly abusive punishments was maintained and available for inspection.

### Les Chênes

- 4.29 Les Chênes opened in 1977, combining an Approved School ethos with a remand centre. We find this to have been a flawed model from its inception. Elsewhere, such establishments were seen as being no longer viable. John Pilling, who undertook a review of Les Chênes in 1980, suggested that the management model of Les Chênes existed more to meet staff needs than children’s needs.
- 4.30 We note that Les Chênes did provide a high quality of specialised education, as described by Lambert and Wilkinson in 1981, which was valued by some residents.
- 4.31 We consider the decision, taken at the outset, to run Les Chênes with teaching staff alone, rather than a mix of care and teaching staff, to have been flawed and that it adversely influenced the ethos and operation of Les Chênes. We find the practice of denying home visits to children, sometimes for weeks, unacceptable even by the standards of the time, and we see no justification for it. We find unacceptable the practice of routinely placing children in a secure room, whether admitted on remand or for welfare placements. This was an objectionable and ill-informed approach to child care

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

- 4.32 We conclude that under both Tom McKeon and Mario Lundy, Les Chênes was managed in a strict and physically dominant way. The culture and ethos of Les Chênes were akin to the outdated model of an Approved School. Much of the culture of Les Chênes was determined by the personality and presence of Mario Lundy: his was a physical and robust approach informed by his own vision of how the school should function and what its goals should be, rather than recognised best practice in care. We also note the number of allegations of physical abuse that relate to this period.
- 4.33 We consider that the heavily structured and physical regime of Les Chênes combined with a staff group unequipped to provide social care and untrained in the use of physical restraint, gave rise to inconsistent and at times excessive use of force by adults towards children. We find this to be a failure of management by Mr McKeon and Mr Lundy.
- 4.34 The problems that Les Chênes faced were compounded by the practice of Magistrates from the late 1990s to remand significant numbers of children at Les Chênes, often repeatedly. The approach of Magistrate Le Marquand reflected an attitude on the island, reflected in the view of the Chair of the Les Chênes Governors, that the place was full of *"little villains"*. We are under no illusion as to the management issues, particularly those posed by individual young people placed on remand at Les Chênes at this time, but we consider that there was a failure of agencies – the school, the Director of Education, the Probation Service, Children's Services and the courts – to work together constructively and decisively to assess and plan to address the needs of individual children.
- 4.35 Instead, several young people experienced a revolving-door existence of remand-release-offend-remand, up to 17 times, with no effective intervention to tackle the roots of their offending behaviour. We have noted many examples of young people who suffered because of this failed approach; the repeated detention of WN72 in the secure suite over a long period, for example, was ultimately a serious failure of management.

- 4.36 In her review of Les Chênes, Dr Kathie Bull noted that the problems of overcrowding; hot-bedding and mixing welfare and remand were already evident from 1997. We consider that the comprehensive failings identified by Dr Bull, relating to all aspects of the running and management of Les Chênes, are failings that should have been identified earlier.
- 4.37 We heard from Ron McLean, who, from 1997 to 2009, chaired the Les Chênes Board of Governors, which later became the Greenfields Board of Governors. There was no interview for appointment to the Boards and the only criterion was that members were of “good standing”. Mr McLean visited Les Chênes every week but he did not speak to residents on their own, nor did he ask to see the secure unit logs. The Governors reported to the Director of Education but, according to Mr McLean, they “*very, very rarely met with him*”. He said that they relied on the Principal to tell them “*if the needs of the residents were being met*” and “*if we were told everything was fine, just accepted that*”. Dr Kathie Bull suggested that the Governors were aware of concerns about Les Chênes over a long period of time, but did nothing about them. This included locking children up using what she described as “*legally dubious methods*”. We conclude that the Director of Education, the Education Committee and the Board of Governors at Les Chênes failed to exercise proper oversight during this period. We consider this a significant and inexcusable failing of governance.
- 4.38 We find that the management of Les Chênes under Kevin Mansell fell substantially below an adequate standard. We attribute the failure in management in large part to circumstances beyond the control of Kevin Mansell and his staff, although their response to the pressures that they were under also falls to be criticised. Notwithstanding the assault and distressing threats to which Mr Mansell and his family were exposed in 2001, and the enormous pressure that he and his staff were under, we find that Kevin Mansell failed to manage his own staff. This pressure resulted in poor decision making – for instance, keeping children in secure cells while having staff meetings – as well as to over-reaction in the use of restraint and the indiscriminate use of the secure facility.

- 4.39 We find that, in that period, Kevin Mansell and his staff were poorly supported by Tom McKeon, then Director of Education, who appears to have distanced himself from Les Chênes in the same period. We find that his evidence to the Inquiry about this period reflected his view that Les Chênes had lost its purpose and way. We conclude that the Education Department failed, in allowing the establishment to flounder, to the detriment of the children for whom it was caring.
- 4.40 In our view, the August 2003 “riot” at Les Chênes was in fact a relatively minor incident of disorder that, as a result of poor handling by staff, escalated out of all proportion. Once the situation began to deteriorate, the shift leader should have called the Acting Principal, Peter Waggott, before he called the Police. The presence and deployment of the Police rapid response team simply exacerbated the situation.
- 4.41 In summary, the ethos of Les Chênes was one of containment and control rather than any therapeutic focus or attempt to divert young people from offending. Throughout its existence, the Les Chênes regime was often harsh, inappropriate and unsuited to the needs of children placed there. We have discussed in the Report specific allegations of abuse and the experiences of individual young people. We consider that the determination to have exclusively teaching staff, with no professional social care input, was a factor in the failures of the operation of Les Chênes.

### Greenfields

- 4.42 We endorse the criticisms of Greenfields expressed by the Howard League in 2008. We find that the prison-based “Grand Prix” behaviour management system, as applied at Greenfields between 2003 and 2007, was totally inappropriate.
- 4.43 We consider that the changes sought to be implemented at Greenfields by Simon Bellwood, when social care staff took over the establishment, were positive and necessary. We echo his sentiments that children in Jersey do not have a voice – or at least not one that is taken seriously or respected.

- 4.44 The Panel visited Greenfields Centre in 2015. We were concerned about the prison-like nature of the facility and by the regime, as described to us at the time of our visit. We felt that the ethos was one of control and containment. We deprecated the seeming absence of a welfare-based approach. We consider that greater clarity is needed on the purpose of such a facility, which should accommodate only children on remand for the gravest offences. Secure accommodation should be an option rarely used, and then for the least necessary time, when there is no other way of minimising the risk of harm that a young person poses to others. Secure accommodation should never be used as a punishment.
- 4.45 The Board of Visitors for Greenfields (modelled on the prison visitor system) was formed in 2004, replacing the Governors, but, according to Mr McLean, it amounted to simply changing the name. It was unclear to whom the Visitors were accountable and, as a result, they felt that nobody in the Health and Social Services Department knew they existed. When asked whether the Governors or Board of Visitors had provided effective oversight Mr McLean initially said that they had done a good job, but, on reflection, having given oral evidence to us, he said: *“I don’t think we did.”*
- 4.46 In 2008, the Howard League said of Jersey: *“There is far too high a level of custody, and we believe that measures should be taken to eliminate it ... thought needs to be given to a more flexible use of Greenfields and a great reduction in its use as a secure facility.”* Nine years later, we echo those sentiments. The existence of Greenfields reflects a cultural malaise on the island with regard to young people who have become marginalised; some sections of society see those young people only as problems to be locked out of sight rather than as young citizens to be assisted to overcome their disadvantages and reach their potential.
- 4.47 In summary, over many decades, there were persistent failures in the governance, management and operation of children’s homes in Jersey. Failings were at all levels: there was no political interest in defining and promoting standards of care and performance in residential care and no will to invest the resources required in child care services. Unsuitable people who

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

### **Political and other oversight of children’s homes and of fostering**

- 5.1 In Chapter 5, we deal with the political and other oversight of children’s homes, fostering services and other establishments run by the States of Jersey, as required by Term of Reference 3. We also deal with the effect that the political and societal environment had on such oversight, including the reporting or non-reporting of abuse and how it was responded to, as required by Term of Reference 4.
- 5.2 We heard from senior elected members who had held responsibility for Children’s Services under the various governance structures that applied at different periods, whether that be the Education Committee Children’s Sub Committee (1960–1995), the Health and Social Services Committee (1995–2005) or Ministerial Government from 2006 onwards. While we do not doubt that these politicians were well intentioned, we heard a number of things that caused us concern.
- 5.3 Keith Barette told us that there was no regular contact between Children’s Services and the Children’s Sub-Committee. He was a regular visitor to the Home, and it is of concern that staff told him he was the only sub-committee member who spent time there. Patricia Bailhache told us that she believed that the role of the Education Committee was to be supportive of the Children’s Officer rather, it seems, than holding them to account. The Sub-Committee was abandoned in 1988, at her suggestion, because it became clear to her that it was achieving little and was not providing any scrutiny.



- 5.4 Bob Hill said that the Health and Social Services Committee did not provide adequate oversight of children's homes because it was not given enough information to allow it to do so. He also told us that, in his view, the Committee tended to focus on health rather than social services issues. Paul Le Claire told us that it was deemed inappropriate to speak out of harmony with other committee members and that the minute-taker would be asked not to record certain points, usually when something controversial was raised. He said that, on reflection, he thought that the Committee had insufficient oversight.
- 5.5 Ben Shenton was Minister for Health and Social Services between 2007 and 2009. He said that the role of politicians was to implement the policies of the States of Jersey, whereas we would have assumed that the role of the Minister was to shape those policies. In his view, progress in Jersey depends on moving within establishment circles. His view was that his predecessor as Minister, Senator Syvret, had been removed from office because he was too outspoken and challenged things publicly. In 2008, Mr Shenton wrote to the Chief Minister, setting out his concerns that the Children's Services Department was not fit for purpose and that there were difficulties with accountability and because departments were operating in silos. He was succeeded as Minister by Deputy Anne Pryke, who told us that politicians set policy and it was the duty of line managers to implement it and to support staff. She did not, however, recall anything being put in place to check whether policy was in fact implemented.
- 5.6 We consider that the level of oversight of children's homes by the Education Committee and its successors was inadequate. The various committees and their professional officers failed to formulate adequate policy or legislation. While we acknowledge that some delays in legislating would be explicable for administrative reasons, as Mrs Bailhache set out, we can see no good reason why the *Children (Jersey) Law 1969* was passed over 20 years after its English counterpart, and the *Children (Jersey) Law 2002* passed over 10 years after its counterpart.
- 5.7 We find that, from the late 1970s, the Children's Sub Committee was largely ineffective in carrying out any oversight. Children's Services were undoubtedly

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

- 5.8 The Education Committee, including the Children’s Sub-Committee, failed to properly carry out its role as a “critical friend” of Children’s Services and did not take adequate steps to ensure that the children for whom they had a statutory responsibility were being suitably cared for. There was a lack of understanding about what their role should have entailed and what oversight actually meant.
- 5.9 Part of this oversight role should have included the commissioning of external inspections – something that was not even considered by Mrs Bailhache in her role as Chairman of the Children’s Sub-Committee. In fact, there was no external inspection of children’s homes or children’s services for approximately 20 years, between the Lambert and Wilkinson Report in 1981 and the first report of Dr Bull in 2001. This is particularly concerning given that there were significant allegations of abuse in three different children’s homes between 1989 and 1991 that were known to Children’s Services, yet there was no review and no inspection, and no difficult questions were asked. This was unacceptable and a further example of inadequate political oversight.
- 5.10 During the period in which the Health and Social Services Committee was responsible for oversight, they appear to have taken a passive role, in which there was very little discussion of children in care. Oversight was inadequate and even if members were insufficiently informed to ask relevant questions of Children’s Services officers, they had a responsibility proactively to seek that information.
- 5.11 We find that the corporate parent system largely failed because, as Deputy Pryke described to us, no one person or department wanted to take responsibility for anything. While, in more recent times, many reports were commissioned concerning children in care, there was nonetheless a failure to respond adequately to recommendations. We find it to be deplorable that the States of Jersey has failed to understand its role as corporate parent and that

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

- 5.12 We find that the Board of Governors for Les Chênes and the Board of Visitors for Greenfields did not carry out effective oversight of the way in which these institutions were run and, as such, they failed the children who were placed there. They also failed to lobby for adequate resources, not least when there were concerns about overcrowding. This was, in our view, an inadequate discharge of their role.
- 5.13 In relation to fostering services, we find the lack of legislative regulation of the fostering of children in care until 1970 to be unacceptable. The Children's Officer was wrong to assert, in 1979, that the Children's Department had a "*minimal role to play*" in private fostering, whereas in fact there was an explicit duty under *Article 57 of the 1969 Law* to "satisfy themselves as to the well-being of the children". The level of boarding-out allowances in Jersey was consistently too low to attract a sufficient number of suitable foster parents, particularly when coupled with the social pressures specific to Jersey, such as high housing costs. It was inadequate that a Fostering Panel was not set up until 2001 and as such this was contrary to good practice that had long been established in the developed world.
- 5.14 We found that there remains a lack of support, guidance and training for foster parents, and that communication between them and Children's Services is inadequate.
- 5.15 In regard to Children's Services' oversight and operation, we looked in detail at their history and operation. It was not until 1958 that the first Children's Officer in Jersey, Patricia Thornton, was appointed. This was 10 years after the creation of such posts under the *Children Act 1948* in England. Between 1984 and 1986, the post of Children's Officer was held by Terry Strettle who had previously worked in England. An article on his leaving said that "*the one major change that Terry Strettle had brought to Jersey was the concept of a move away from children in care to children in the community ... living with their families*".

- 5.16 Anton Skinner was appointed Children's Officer in 1986, when Terry Strettle's short-term appointment ended. We heard detailed evidence of structural changes that Mr Skinner and his successors initiated in Children's Services between 1986 and the 2000s. These are set out in detail in Chapter 5, as are the findings of the various reports that were commissioned during this period.
- 5.17 We consider that in Jersey there has been no political appetite for addressing social issues concerning the welfare of children. The focus has been on structure and process, with little consideration given to the necessary quality of leadership, the performance of staff or the experience of children in the system. We find that leadership generally has been lacking, and that the focus in Jersey has instead been on administration and hierarchy.
- 5.18 We note the many reports on the problems in child care services that have been commissioned over the years. While some recommendations have been implemented, we find that many, including some of significance, have not. Costs and prioritisation seem to have been constant issues holding back progress. There has been, for many years, a failure to adopt a strategic approach and to develop policies to meet the needs of children and young people in Jersey.
- 5.19 A key factor in these failings has been that Jersey has struggled to recruit and retain senior social work staff. As a result, the practice has been to promote existing staff who have sometimes lacked the necessary leadership qualities and senior management skills. In saying this, we do not doubt the commitment and dedication of these individuals in their front line roles.
- 5.20 Another major factor in the failure of the child care system has been that, since 1945, Jersey has become disconnected from mainstream social care developments and practice elsewhere in the world. It is our view, echoed by some witnesses, that because Jersey has not known "*what good looks like*", the island has not been able to deliver services that were fit for the purpose of looking after vulnerable children.
- 5.21 We note that while child protection guidelines were initially published in 1991 and revised a number of times subsequently, producing documentation does

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

### **Changes in and development of child care practice from 1945**

- 6.1 Chapter 6 of the Report deals with changes in child care practice over the years and reflects the report prepared for the Inquiry by Professors Bullock and Parker. It links with the report prepared by Richard Whitehead, who conducted a review of child care legislation in Jersey from 1945. This allows for comparison between developments in Jersey and those in the UK. These reports deal with Term of Reference 5, which asks for a chronology of significant changes in child care practice and policy. A summary chronology of key events also is included at Appendix 1.
- 6.2 The development of child care legislation in Jersey has been influenced and modelled on UK legislation, and in particular that pertaining to England and Wales. The introduction of legislation in the island tends to be behind that of the UK, often by many years. The *Children (Jersey) Law 1969* mirrored the UK's *Children Act 1948*, for instance.
- 6.3 Richard Whitehead said that in the very small jurisdiction of Jersey "*some major changes just take a long time because there are not many people working on them*". Former Minister Ian Le Marquand said, however, that the priority for the States and the electorate was (and remains), the maintenance of the low tax status on the island. Chief Minister Senator Ian Gorst told us that it was not fair to suggest that financial legislation received greater priority than child care legislation. Others with experience of the political system disagreed. Wendy Kinnard, the former Home Affairs Minister, told us, however, that legislation relating to the finance industry would "definitely" take priority due to the influence of outside agencies such as the IMF. Similarly Deputy Higgins thought that legislation relating to financial regulation was certainly "*top of the pile*".
- 6.4 We consider that the delays in Jersey in adopting good practice and legislation informed by modern thinking can be explained only by a lack of

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

### **Experience of witnesses**

- 7.1 Term of Reference 7 requires us to consider the experience of those witnesses who suffered abuse or believe they suffered abuse.
- 7.2 We considered allegations of abuse across residential homes of all types and in foster care. Our consideration included abuse alleged to have been perpetrated by staff, foster carers and other residents and by others including visitors to the homes.
- 7.3 It was not part of our function to make findings of fact about individual cases but rather to consider whether there were cultures in which abuse was permitted to flourish and whether steps were taken to deal with it when it occurred. We make findings on these issues across other chapters of the Report.
- 7.4 Personal experiences of Jersey's care system are at the heart of this Inquiry. We heard many lengthy and distressing histories in the course of the evidence. A brief summary of the evidence that we heard about individual experiences is set out in Appendix 2. These short accounts are not intended to encompass the full extent and nature of the histories we heard. They do, however, give an insight into the lives of children in Jersey's care system from the 1940s to the 2000s and highlight the degree and nature of abuse that many suffered. We pay tribute to the courage of all those who shared their childhood experiences with the Inquiry.
- 7.5 We find that, on the large amount of evidence before us, there can be no doubt that many instances of physical and sexual abuse and of emotional neglect were suffered by children in the care of the States of Jersey throughout the period of review. That abuse and neglect has had far reaching consequences for many of them throughout their adult lives.

## Reporting of abuse

- 8.1 In Chapter 8, we deal with the reporting of abuse, as required by Term of Reference 8, which asks us to identify how and by what means concerns about abuse were raised and how and to whom they were reported. We are asked to establish whether systems existed to allow children and others to raise concerns and safeguard their wellbeing, whether these systems were adequate, and any failings they had.
- 8.2 Until the 1990s, there is no evidence of a system for victims to report abuse. In the Report we detail and consider many instances of abuse of all types over the whole period of our review, across all forms of care settings in Jersey and analyse the reporting of abuse in each of them.
- 8.3 It is important to acknowledge how inordinately difficult it is for a child, especially a child with little experience of a loving and nurturing family life, to express concerns about their treatment, let alone find adults who take them seriously. We found that concerns about abuse had been raised by children as well as by their friends, relatives and teachers, CCOs and residential care staff. These matters had been reported to a variety of people, including Children's Services and the Police.
- 8.4 The creation of Childline in the UK in 1986 did provide an outlet for some children in Jersey to report abuse, but this did not constitute a suitably comprehensive system for children in care in the island. As with other elements of the care system in Jersey, policies and procedures on complaints by children were decades behind those operating elsewhere. By 2005, a formal system for complaints was in place. The existence of a procedure alone, however, is insufficient evidence of its efficacy or of the extent to which children knew about or had confidence in it. One procedure we saw required a child to talk with the head of the home if they wanted to arrange to see an independent person. This was a potentially daunting process for a child with worries about mistreatment. Further, we heard that Children's Services staff were not trained or always made aware of complaints systems and procedures for children in place by the early 2000s. In summary, children in the care system in Jersey have been powerless for decades and it is to our

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

- 8.5 Many witnesses told us that, as children, they did not feel able to report abuse because they felt that they would not be believed. Sadly, some children did not recognise their care as abusive and accepted it as a normal part of life; others were only able to speak of their abusive experiences years later in their adult life; for some former residents, the experience of becoming a parent triggered a reaction about how they had been treated as children.
- 8.6 It is our conclusion that attitudes in Jersey towards vulnerable children influenced for many years how children in the care system were treated, including how allegations about mistreatment were handled. Over part of the review period, Jersey society remained patrician and hierarchical, and children in care were marginalised. Such attitudes made it more likely that children would not be believed, and contributed to their fear of coming forward.

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

- 9.1 Term of Reference 10 requires us to consider how the Education, Health and Social Services Departments dealt with concerns about alleged abuse, what action they took, whether these actions were in line with the policies and procedure of the day and whether those policies and procedures were adequate.
- 9.2 We considered homes, fostering services and individual cases and have made findings where we consider it appropriate. These are set out in considerable detail in the Report. We have also included the responses of witnesses to allegations of abuse that were made against them or others. Where we are able to make findings, these are in the main that the responses to allegations of abuse were inadequate. In this summary we highlight a few notable cases.
- 9.3 A large number of former residents of HDLG gave evidence to the Inquiry or to the SOJP about Morag Jordan and her harsh treatment of children. The weight of evidence and the fact of her criminal conviction demonstrate that



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

- 9.4 Henry Fleming lived close to HDLG and was interacting with residents of the Home. Concerns were raised about him in the mid-1970s. In August 1975, he admitted to the Police that he had engaged in sexual activity with children from the Home. He described how he had indecently assaulted children over a period of two or three years. He was convicted and sentenced to two years' imprisonment. We found that children had been visiting him for several months before any investigations as to his suitability to entertain children had been carried out. There was, at the very least, an awareness that children had been receiving alcohol and cigarettes from him. By early August 1975, his sexual assaults on children from HDLG were known about. However, this was only reported to the Connétable when initial attempts to discourage children from visiting had failed. We consider this response to have been inadequate and as a result those charged with the care of children failed in their duty to take adequate measures to protect those children from sexual abuse. Furthermore, we noted a memo that suggests that there was no plan to inform parents about what had happened to their children. We consider this to have been inadequate, and we are critical of the possible motivation: to protect reputations.
- 9.5 In 1988, two residents at Clos des Sables disclosed to CCOs that Les Hughes had sexually assaulted one of them. The girl said that she did not want anything said to either Mr or Mrs Hughes, who were the Houseparents at Clos des Sables. The Houseparents were not informed. We find that this response

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

- 9.6 Anton Skinner was advised by a Crown Advocate that he should look into the failure of his staff member to take action, and to consider what action should be taken. The Crown Advocate also said to him that he would *"no doubt wish to give thought to establishing a fixed policy by virtue of which any complaint, no matter how apparently ill founded will be given formal attention"*. Mr Skinner failed to follow up on this advice; neither did he follow up on his stated intention to prepare an in-depth report into what had happened. We find this inexplicable and inexcusable. The Education Department's failure to take any action against the staff member was, in our opinion, another failure to acknowledge and tackle failures in responding to disclosure of abuse.
- 9.7 In the Report, we deal, at length and detail, with the situation at Blanche Pierre, where Jane and Alan Maguire perpetrated abuses against children in their care and recorded their actions in the Home Diaries. A prosecution against the Maguires was pursued but then abandoned in 1999, following which Dylan Southern, the Head of Mental Health Services, was commissioned to produce a report as to whether there was a disciplinary case against Jane Maguire.
- 9.8 We find that it was adequate and appropriate for the Health and Social Services Department to have carried out an investigation into Jane Maguire in 1999. We consider that Dylan Southern wrote a clear and measured report and we reject the criticisms levelled at him by Anton Skinner. Despite Mr Southern's identification of failings on the part of Children's Services, and in

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

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

### **Response of the SOJP to concerns about abuse**

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

#### Organisation of child protection investigations in SOJP

- 10.2 The Report sets out the history of specialist child protection work in SOJP, from the early Child Protection Team to the current Public Protection Unit. Many officers, in their evidence to the Inquiry, recognised that the rarity of serious crime in Jersey meant that senior officers would often not have the experience that officers of similar rank in the UK would have.
- 10.3 We have described the appointment and approaches of officers from the UK – specifically, Graham Power, Lenny Harper, Michael Gradwell and Alison Fossey – and their roles, both in developing the established specialist child protection unit in Jersey and in the response to the allegations of abuse that emerged throughout Operation Rectangle. The key role of now-DCI Fossey in building the team and developing its professionalism and expertise is highlighted.
- 10.4 The Report addresses the struggles that the team faced to secure sufficient resources. We concur with now-DCI Fossey's view that "*Child protection presents the biggest threat and risk to any police force in the country. Jersey*

*didn't recognise that, therefore the resources did not get prioritised to that".*

We accept that, at times, the child protection unit of SOJP was under-resourced and we accept Graham Power's evidence that nobody deliberately starved the team of funds. Rather, it was subject to constraints shared by other SOJP departments, though notably, and commendably, it was, in 2006, the only fully staffed unit in the force. DCI Fossey told us that when she joined the then Family Protection Team in 2005, she noted there were many child protection investigations but few prosecutions.

- 10.5 We considered the role of the Honorary Police in the prosecution of child protection cases. By the early 1990s, both the SOJP and Children's Services were expressing concern about the role of Centeniers in child abuse cases. One particular Centenier was thought to be unwilling to pursue such cases. Anton Skinner, then the Children's Officer, wrote to the Bailiff in 1991, expressing concern about the lack of protection of child witnesses in the Magistrate's Court, caused in his view by the fact that Centeniers, not professional prosecutors, presented the cases. Two years later in 1993 Marnie Baudains also highlighted a number of difficulties in the prosecution of child abuse cases arising from the fact that a Centenier, not a lawyer, was responsible at that time for prosecution up to and including the Magistrate's Court stage. We consider that these criticisms were well founded. We conclude that the role given to the Honorary Police and the attitudes of some Centeniers contributed to insufficiently robust approaches to the prosecution of child abuse cases and a consequential lack of confidence by victims and other professionals in the system.
- 10.6 We consider that changes in recent years, including the appointment of force legal officers requiring that prosecutions be undertaken by legally qualified personnel, have addressed the problems in the system. The Report also describes the role that the Honorary Police had up until the early 2000s in responding to cases of child abuse, child neglect and domestic violence, and the concerns that existed in the SOJP and Children's Services that an overly informal or lenient view was often taken of such serious offences by the Honorary Police. We commend the efforts and persistence of Marnie Baudains, Bridget Shaw, Alison Fossey and their colleagues in lobbying

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

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

#### Working relationship between SOJP and Children's Services

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

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

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

#### SOJP investigations into Victoria College, Paul Every and Sea Cadets

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

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

#### The origins of Operation Rectangle

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

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

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

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

#### Operation Rectangle – political involvement

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

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

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

- 10.17 The Attorney General, William Bailhache QC, recommended to Mr Power that suggestions of political cover-up would best be dealt with by asking an external force to conduct the investigation of allegations of abuse. Mr Power was clear that the Attorney General was not seeking to discourage an investigation but was asking for it to be demonstrably independent. Mr Power took extensive advice, including from outside the island, on the original prosecution decisions in relation to the Victoria College, Paul Every, Jane and Alan Maguire and other earlier cases. He concluded that there was no basis for a criminal investigation into any cover-up in these cases, based on the available files. There was no review of whether the Police investigation in these cases was in any way flawed. We accept that both the Attorney General and Graham Power acted in good faith in their approach to the allegations of past cover-up. We believe that Graham Power acted appropriately in seeking independent legal opinion.
- 10.18 We note that, following the publication of a Serious Case Review about which Senator Syvret raised concerns, an independent review of child care by Andrew Williamson from the UK was launched. The Council of Ministers also decided that a public inquiry would be held in due course.
- 10.19 We have briefly recounted in the Report the events following on from Senator Syvret's scathing public criticisms of the performance of his own department, of which he had been Minister for eight years, to his dismissal as a Minister. We find that Stuart Syvret highlighted relevant issues about child abuse that needed to be addressed to ensure the protection and safety of children in Jersey. His actions did not amount to political interference with Operation Rectangle.
- 10.20 We agree that Mr Syvret's public criticisms of civil servants were inappropriate and did not assist his cause. We accept that Frank Walker and Bill Ogle were genuinely troubled by his conduct in this respect, and we do not believe that the attempts to remove him were conducted with the intention of covering up child abuse. In those circumstances, further consideration of the reasons



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

- 10.21 The Inquiry is not required to determine whether policing decisions were right or wrong, except in so far as those decisions have a direct relevance to the Terms of Reference, specifically the response of the SOJP to the abuse allegations and the process by which files were submitted to prosecuting authorities and the way in which decisions to prosecute were made.
- 10.22 A great deal of media attention was generated by the SOJP press statement dated 24 February 2008, which included the assertion that *“the partial remains of what is believed to have been a child”* had been found at HDLG. Subsequent scientific analysis revealed that the item, believed at that time to be part of a child’s skull, was not human bone and was probably coconut shell. Graham Power agreed that making the assertion quoted above in the press statement was *“not good”*. Mr Power explained that Mr Harper believed that the fragment found was part of a skull because of the preliminary view of the forensic scientist on site. He accepted that more should have been done to correct inaccurate press reporting. The Inquiry has also seen correspondence and notes of meetings involving politicians, the Attorney General, Graham Power and Lenny Harper, in which the Attorney General urged politicians not to intervene. He also sought to persuade the SOJP to correct inaccurate reporting.
- 10.23 The Attorney General stated repeatedly his concern about the effect of publicity on any prosecutions. Senator Ben Shenton was highly critical of the handling of the media interest in the investigation, and he expressed this strongly in a letter to Senator Wendy Kinnard, who was Minister with responsibility for policing. Mr Power, who saw the communication, saw this criticism of Ms Kinnard's oversight as political interference in the HDLG investigation. We do not accept that this was the case. On 3 March 2008, Mr Walker, while acknowledging that questions might need to be asked about the conduct of the media-handling aspects of the investigation, tried to calm matters by urging all Ministers to desist from comment and questions about the investigation until it was concluded.

- 10.24 On 27 March 2008, the Council of Ministers announced that a public inquiry would take place at the conclusion of any criminal proceedings. Four days later, Mr Walker and his wife were given a tour of the crime scene by Mr Harper, who told them that new forensic evidence indicated that no murders had taken place. No public announcement was made to this effect. In May 2008, further specimens, including children's milk teeth and bone fragments, underwent forensic testing. Subsequently, no findings emerged that warranted the launch of a homicide investigation.
- 10.25 It became public knowledge that the Director of Education at the time, Mario Lundy, was suspected of the physical abuse of children. Graham Power said that, at a meeting attended by himself, Bill Ogle and Mario Lundy, Mr Ogle said: *"If anyone wants to get Mario they will have to get me first."* Graham Power said that the statement was met with applause by some of those present and he took this incident as indicating the closing of ranks by the *"in crowd"* against the *"threat"* of Operation Rectangle. His view was that politicians and those in government were willing to cover up child abuse in order to protect Jersey's reputation.
- 10.26 Former Minister Wendy Kinnard told the Inquiry that she did not believe that Ministers wanted to cover up abuse; they just wanted the issue to go away, and one way of achieving that was *"to minimise it"*. The public perception at that time was, we believe, succinctly dealt with in the submissions to this Inquiry by the JCLA:

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

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

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

- 10.28 We have considered whether Sir Philip's words indicated a belief on his part that the reputation of Jersey was of more importance than the child abuse investigation. We cannot accept that a politician and lawyer of his experience would inadvertently have made what he told the Inquiry was an "*unfortunate juxtaposition*" of words. We are sure that the way in which Jersey is perceived internationally matters greatly to him. His linking of Jersey's reputation to the child abuse investigation was, we are satisfied, a grave political error, rather than a considered attempt to influence the course of the police investigation.
- 10.29 We find that there was disquiet among Jersey's politicians, up to and including the Chief Minister, Frank Walker, about the effect on the island of the publicity being generated by Operation Rectangle. Nevertheless, we find that Frank Walker and the majority of politicians accepted the strong advice of the Attorney General and did not seek actively to interfere. We find that Ministers in general recognised that, however unpalatable the outcome of Operation Rectangle might prove to be, the Police investigation had to be permitted to run its course unhindered. The alternative, leading to public accusations of cover-up, would have been far worse for Jersey's reputation, and we find that politicians recognised that fact.
- 10.30 Nevertheless, we accept that CO Graham Power would have felt under pressure from questions raised with him about Police handling of media and publicity, and also the conduct of DCO Lenny Harper. The questions raised by Frank Walker, Bill Ogley and others undoubtedly reflected genuine concerns but caused Mr Power to believe that he did not enjoy the political support that was being asserted in public.

#### Operation Rectangle – SOJP relationship with LOD

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

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

- 10.32 We have concluded that the relationship between the Operation Rectangle Police team and the Law Officers was poor almost from the outset, largely because of the lack of trust on the part of the Police in the ability of the Law Officers to make decisions that would be perceived by the public as fair and independent. Relations worsened substantially from February 2008, with the increasingly hysterical and inaccurate media reporting of the progress of the Police investigation. A crisis in the relationship occurred in July 2008, with the issuing by Lenny Harper of a press release, criticising the decision not to prosecute WN279 and WN281.
- 10.33 The mutual distrust in the working relationship undoubtedly caused problems in an investigation that was difficult in any event. The Police were investigating allegations of abuse, which in some cases were alleged to have occurred many years in the past. Evidence of such abuse is, by very reason of the passage of time, often extremely difficult to obtain. Once evidence is obtained, prosecutors have to exercise fine judgement in order to determine whether prosecution is justified. A fractious working relationship between Police and lawyers could only have made the tasks for each side more fraught with difficulty. We have concluded, however, that the essential policing work and the process of giving legal advice and making prosecuting decisions were not significantly affected by the disputes. The Operation Rectangle Police team was staffed by experienced officers, with now-DCI Fossey having a leading role as Deputy SIO. We have seen no evidence to indicate that the

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

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

#### Suspension of Graham Power

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

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

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

- 10.38 Those responsible for Mr Power's suspension did not heed the advice of the Solicitor General or the Attorney General about the risks of reliance on an interim report by the Metropolitan Police Service into the management of Operation Rectangle, and the need to show to Graham Power any report on which they were relying and permit him to comment on it. They also did not accept the wisdom of awaiting the full Metropolitan Police Service report before taking action. We find that David Warcup exaggerated to Bill Ogle the extent to which his own concerns were supported by the Metropolitan Police Service interim report. We also find that Andrew Lewis used the interim report for disciplinary purposes, knowing that this was an impermissible use.
- 10.39 We accept the evidence of the then Attorney General, William Bailhache QC, who understood that the decision to suspend Graham Power had already been made by the evening of 11 November 2008, in advance of the meeting with Mr Ogle and Andrew Lewis the following day. His evidence to us on this point was at odds with the evidence of Bill Ogle. We prefer the evidence of Mr Bailhache. It is clear to us that when Graham Power attended the meeting on 12 November 2008, his suspension was inevitable. We accept Graham Power's evidence that he was given time "*to consider his position*" – in other words, to resign as an alternative to suspension;
- 10.40 We find that Andrew Lewis lied to the States Assembly about the Metropolitan Police Service report, stating that he had had sight of it when he had not. We can readily see why these acts have given rise to public suspicion that all or some of those involved were acting improperly and that they were motivated by a wish to discredit or close down investigations into child abuse.
- 10.41 We recognise that there were, at the time of Graham Power's suspension, genuine reasons for concern about some aspects of the past conduct of Operation Rectangle, in particular, the media handling, and that there may well have been reasons to investigate whether (a) there were failings in the conduct of the operation; and (b) if there were, the extent to which Graham Power was responsible for them.
- 10.42 We cannot be sure why Frank Walker, Bill Ogle and Andrew Lewis acted as they did, or why Andrew Lewis lied both to the States and to us. Frank Walker

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

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

### **Prosecution decisions**

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

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

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

- 11.3 It does not matter whether Mr Griffin QC would have come to the same prosecuting decisions. We recognise that two competent individuals exercising professional judgement may reasonably reach different views. What he was reviewing was the professional competence of those involved in the decision-making process.
- 11.4 The decisions reviewed were mainly, but not all, made in the course of Operation Rectangle. They were a representative sample of the working practice of the prosecuting authority. Mr Griffin QC concluded that the decisions were appropriately and properly taken. It was then for the Inquiry to reach its own conclusion, taking this opinion into account.
- 11.5 In Jersey, the head of the prosecution service is the Attorney General, who is also the principal legal adviser to the States of Jersey. While this is comparable with arrangements elsewhere, it has been the subject of some criticism in Jersey. The role was, however, reviewed by Lord Carswell in 2010, and he concluded that the current arrangement should continue. We heard from John Edmonds, Director of the Criminal Division in the Law Officers' Department, who assured us that, during Operation Rectangle, he never felt uncomfortable professionally with what was being done and the decisions that were taken.
- 11.6 Prosecution decisions in Jersey are made in accordance with the same two-stage test as is applied in England and Wales. Stage one requires an objective assessment of the evidence, addressing the following question: is a prosecution more likely than not? If that test is passed, then a subjective test of the public interest is applied. We heard in some detail from former Attorneys General as to how they had applied these tests and reached their decisions. While Nicholas Griffin QC pointed to some cases where he felt there may have been a conflation or inappropriate application of the public interest test, he considered that the test had been appropriately applied in other cases, some of which he said were *“very difficult from a lawyer’s point of view”*.
- 11.7 In Jersey, charging decisions are usually taken by Centeniers, who do not have any legal training. In Operation Rectangle, charges were brought by



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

- 11.8 We set out detail of the procedures regarding prosecution that were put in place for Operation Rectangle. We found that the approach of the SOJP remained essentially the same throughout the operation; the Police wished to prosecute alleged offenders where there was evidence to justify prosecution. There was, in our view, no improper attempt, following the arrival of Mr Warcup and Mr Gradwell into the SOJP, improperly to close or reduce the scope of the investigation. We have no doubt that, throughout the length of the operation, all policing and prosecuting decisions were made conscientiously and properly. We set out, in some detail, the cases that Nicholas Griffin QC reviewed and the opinions that he offered. These include some of the cases that have caused most concern, such as the prosecution of Alan and Jane Maguire. We also detail a number of other cases that were not reviewed by Nicholas Griffin QC, but about which we received evidence. We set out, for each case, the view we reached as to the decision-making process. In each of these cases we found that the decision-making process was carried out professionally and appropriately.
- 11.9 We gave consideration to the law on corroboration that applied in Jersey. This required there to be corroboration of the evidence of a child under 14 before a defendant could be convicted on that evidence. In 1991, Anton Skinner, the Children's Officer, wrote to the Bailiff, requesting an urgent review of this law because of *"an inability to progress legally towards criminal prosecution in an increasing number of cases where there has been no doubt in the minds of investigating officers that grave offences against children have occurred"*. He went on to say: *"regrettably the law as it currently stands does not appear to be able to protect the interests of children in the matter of child abuse and most particularly sexual abuse"*. It took until 1997 before the law was changed so that there was no longer a bar to prosecution in which the evidence of a child was uncorroborated. A judge was, however, still required to give a warning to the jury of the dangers of relying on the uncorroborated evidence of children or complainants of sexual abuse.

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

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

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

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

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

### **From findings to recommendations**

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

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

Ten fundamental failings in Jersey's care system

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

- (i) **Failure to value children in the care system, listen to them, ensure they are nurtured and give them adequate opportunities to flourish in childhood and beyond.** This includes lack of investment in the recruitment, management, supervision and continuing development of staff with suitable backgrounds and skills to care for children.
- (ii) **Failure to have in place an adequate legislative framework that prioritises the welfare of children in need or at risk.** While the States of Jersey has always been able to provide sufficient resources to keep pace with developments in international financial law, Jersey's child care legislation has lagged behind other jurisdictions in the developed world – often by decades.
- (iii) **Failure to keep pace with developments in social policy, child care practice and social work standards in the developed world.** For example, in Jersey there has been an ill-considered, misguided and potentially harmful approach to secure accommodation that was used routinely for children whose needs would have not have met the threshold for secure detention elsewhere and without the thorough assessment or rigorous safeguards that were in place in other jurisdictions.
- (iv) **Failure to plan and deliver services in an effective, targeted manner to achieve positive, measurable outcomes for children.** For decades, there was little evidence of a considered approach to the needs of and desired outcomes for individual children. At a strategic level, there was a marked

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

- (v) **Failure to establish a culture of openness and transparency, leading to a perception, at least, of collusion and cover-up.** Jersey's culture has not encouraged the reporting of poor and abusive practice. At times, efforts to protect the island's reputation and international standing have led to insufficient acknowledgement of the gravity of the Island's failings and the egregious nature of some of the abuses perpetrated on children in its care. Such attitudes have fostered the suspicion, within parts of the community, that most politicians and States employees cannot be trusted and that abusive practices have been covered up.
- (vi) **Failure to mitigate negative effects of small island culture and its challenges.** Failures have included ignoring or failing to manage conflicts of interest and prioritising the welfare of staff over the needs of children. Social connections have meant that, at times, there has been insufficiently robust professional challenge to poor practices.
- (vii) **Failure to make sufficient investment in staff development and training.** Dedicated staff have not been truly valued, while unskilled staff have been allowed to run institutions or care for children with severe and enduring emotional needs.
- (viii) **Failure to adopt policies which would promote the recruitment and retention of staff with essential skills in child welfare and child protection.** Incentives and expedited residency qualifications are available from the States to draw highly valued individuals and financial organisations to the island. In contrast, little effort has gone into creating the incentives that would make Jersey competitive in recruiting and retaining exceptional managers and staff to care for Jersey's children, who could be seen as the island's most valuable asset.

- (ix) **Failure of the States of Jersey to understand and fulfil corporate parenting responsibilities, including adequate aftercare of children who have been looked after by the state.** The overwhelming majority of adults who have been in the care system, and whose stories the Inquiry heard, still suffer from the effects of abusive or emotionally neglectful childhoods in the care system, their difficulties often compounded by being turned out, unsupported, into a world with which they were singularly ill equipped to cope.
- (x) **Failure to tackle a silo mentality among public-sector agencies.** States departments and institutions have been characterised by territorialism and protectiveness rather than openness to pooling resources and learning. As a result, there has been a lack of a comprehensive strategy to secure the best interests of children in the island.

#### The current state of care for children in Jersey

- 12.4 Unfortunately, these are not only historic failings. In relation to current services for children, foster carers told us in 2016: *“The service is failing our children, leaves them very vulnerable and has not learned any lessons whatsoever no matter how many SCRs have occurred.”* Interim managers arriving in 2014 found a management style within the residential sector, which was *“not conducive to keeping children safe”*. They found children at risk in the community because care orders were being used inappropriately or not at all. Young people currently in the care system told us that they feel that they have no effective mechanism for making representations or raising concerns. They told us that they are not being listened to. We learned that staff in residential care settings still relied on outdated containment and behaviour management methods of care rather than approaches geared to creating the therapeutic environments and relationships to enable children to recover from adverse experiences.
- 12.5 We heard that lessons of the past have not been learned over long periods because of a *“moribund”* senior management that had come about because of *“too many internal promotions over too long a period”*. In its submissions to the Inquiry, the States of Jersey acknowledged that there had been a reluctance by staff in child care services to engage in robust professional

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

- 12.6 There was a strong contrast between the positive accounts by some recent managers of improvements and achievements in Children's Services and other evidence we heard. We do not believe that the Inquiry was intentionally misled: we believe that the discrepancy between how some staff perceive the quality of service and how it actually functions is a reflection of their "*not knowing what good looks like*" in modern child care practice.
- 12.7 Service quality has also been affected by Jersey's inability to recruit and retain sufficient numbers of high-calibre child care professionals.
- 12.8 For all those reasons, we believe that, as late as the end of the Inquiry's hearings, aspects of Jersey's services for children remained not fully fit for purpose. In the light of all the evidence that it has heard, the Panel considers that children may still be still at risk in Jersey and that children in the care system are not always receiving the kind or quality of care and support that they need.

#### Hope for the future

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

#### Lessons to be learned

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

- (i) **The welfare and interests of children are paramount and trump all other considerations.** Traditional values, operating and management practices, the needs or employment status of staff, convenience, HR practices and the reputation of the island should all be secondary considerations to the interests and welfare of children.
- (ii) **Give children a voice – and then listen to it.** All children are different, and the “listen to children” box cannot be ticked by providing one process or one set of documentation.
- (iii) **Be clear about what services are trying to do and the standards which they should attain.** Jersey needs to articulate its aspirations and the standards it seeks for the performance of staff, for children in its care and wider services for children in the island. It needs to have clear thresholds for state intervention in families, including in respect of youth offending.
- (iv) **Independent scrutiny is essential.** Regular scrutiny of child care law, policy and practice by individuals or agencies entirely independent of Jersey is essential. While in Jersey, persons involved in such work should avoid even the perception of conflict of interest or partiality.
- (v) **Stay connected.** Jersey must ensure that child care and youth justice legislation, policy and practice are not only compliant with current standards in the developed world, and with ECHR and with UNCRC principles, but also that legislation policy and practice are regularly being informed and evolving in line with research and developments.
- (vi) **Investment is essential.** Every child in Jersey is key to securing the island’s future, prosperity and international standing, but that will not be achieved without according the island’s children’s services priority comparable to its financial services.
- (vii) **Quality of leadership and professionalism are fundamental requirements.** Services for the most vulnerable children should not be delivered simply by whoever happens to be available.
- (viii) **Openness and transparency must characterise the culture of public**

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

## **Recommendations**

- 13.1 Many recommendations made over the years in previous reviews have focused predominantly on developing processes, structures and procedures instead of identifying and setting out a roadmap for pursuing desirable outcomes and for transforming service users' experience. We have sought to avoid this and have also set out in the Report some features that we believe should be part of an approach by the States of Jersey to these recommendations. The key changes required are not procedural but cultural. The States of Jersey must commit to and invest urgently and vigorously in a new approach to overseeing, supporting, developing, delivering and scrutinising its services for children.
- 13.2 The "Jersey Way" should be one of intolerance of poor performance, having high aspirations for every child in the island, commitment to securing the best-quality services to enable disadvantaged children to have equal opportunity to fulfil their potential, and creating a culture where staff development is valued and promoted.
- 13.3 The experience of other inquiries and international research suggests that grounding recommendations in the realities, knowledge and experience of people in Jersey will improve the chances of successful implementation and successful outcomes. We also believe that they offer a strong opportunity for redeeming the heritage of Jersey's care institutions and transforming it into a legacy of safe, nurturing care for future generations of Jersey's children.
- 13.4 We have also taken the view that, rather than specify in detail how recommendations should be implemented, it is better to place the responsibility for deciding what will work best for Jersey's children in the



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

#### RECOMMENDATION 1: A Commissioner for Children

- 13.5 We recommend that a Commissioner for Children be appointed to ensure independent oversight of the interests of children and young people in Jersey. Such a position should be enshrined in States legislation and should be consistent with what are known as the Paris Principles, as is the case with other Children's Commissioners across the UK and Ireland.
- 13.6 The independence of a Commissioner is essential if there is to be confidence in the post, and, to that end, we recommend that consideration should be given to any possibility of a joint appointment with other jurisdictions. We consider that this could only enhance the perception of independence. We consider this to be such an essential appointment that we make it clear that pursuit of potential joint arrangements should not delay the statutory establishment of a Commissioner for Children in Jersey.

#### RECOMMENDATION 2: Giving children and young people a voice

- 13.7 Alongside the appointment of a Commissioner, we consider that other steps are necessary to ensure that children in Jersey are given a voice. An effective complaints system is one key element in the structures that are necessary to ensure that looked after children are safe, and, to that end, we recommend that the current complaints system is replaced with one that is easily accessed and in which children and young people have confidence. The outcomes of complaints should be reported regularly to the relevant Minister, who, in turn, should present an annual report to the States.
- 13.8 This improved system should include the appointment of a Children's Rights Officer, who will have responsibility for ensuring that children in the care system, irrespective of where they are accommodated, are supported to ensure that their voice is heard and that the matters they raise are addressed.

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

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

#### RECOMMENDATION 3: Inspection of services

- 13.10 A further essential element of keeping children safe is having an empowered, professional and truly independent inspectorate. Between 1981 and 2001, there were no independent inspections of services for children, and, since 2001, there have only been occasional ad hoc inspections. We believe that the current plans for an internal inspectorate are encouraging, but we also consider that an external element of scrutiny is required.
- 13.11 We recommend that Jersey establish a truly independent inspection arrangement for its children's services, which will have the confidence of children, staff and the wider public. We set out in our Report the elements essential to ensure the inspectorate is truly independent. We believe that it is vital that, within 12 months of publication of our Report, a statutory basis for inspection is established. We also set out proposals for including experienced lay persons and care-experienced young people in inspection teams.

#### RECOMMENDATION 4: Building a sustainable workforce

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

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

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

#### RECOMMENDATION 5: Legislation

- 13.14 Legislation for children in Jersey has lagged behind the developed world. We have set out suggestions for Jersey keeping pace with other jurisdictions, including developing collaborations with English authorities. We heard from witnesses a view that the *Criminal Justice (Young Offenders) (Jersey) Law 2014* should have a section inserted into it recognising that the welfare of children should be a primary consideration. We agree with this proposal, but it is our view that this in itself would not be sufficient unless the whole system were amended to centre on the welfare of the child.
- 13.15 We recommend therefore that the youth justice system move to a model that always treats young offenders as children first and offenders second. It is also essential that those charged with dealing with children in a judicial capacity should have a sound understanding of the needs of young people and the issues that can impact on their lives. To that end, we recommend that a suitable training programme be put in place for the judiciary, including a requirement for refresher training to ensure that all carrying these onerous responsibilities are kept briefed on the latest thinking and research.

RECOMMENDATION 6: Corporate parent

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

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

RECOMMENDATION 7: The "Jersey Way"

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

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

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

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

#### RECOMMENDATION 8: Legacy issues

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

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

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

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

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

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

### **Concluding remarks**

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

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