Good afternoon,

It's good to see everyone here. I'm going to speak for the next hour to present to you our main findings and recommendations.

To start at the beginning, I am Frances Oldham, Queens Counsel. I have sat, in this inquiry, with two Panel members. Alyson Leslie and Professor Sandy Cameron. Their extensive background in social care generally and childcare in particular was of great assistance to me throughout the Inquiry.

Our Remit

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. The final submissions to the Inquiry on behalf of the States of Jersey stated, and I quote:

"It is without doubt and of incalculable regret that children have been failed whilst in the care of the States of Jersey." Unquote.

Those failings impacted upon children who were 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.

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

The Inquiry sat for 149 days of hearings and consultations, allowing more than 200 witnesses to give their evidence directly to us. We also considered the evidence of more than 450 people who were former residents in Jersey's care system or otherwise connected with it.

On behalf of the Panel, I would like to thank all of you who assisted with the work of this Inquiry. Your contributions have been invaluable. We wish to ensure that Jersey's most vulnerable children are given the standard of care they deserve, and that every child needs, to thrive both in childhood and as adults.

I turn now to the history and social context of child care in Jersey

The fifteen Terms of Reference set by the States of Jersey cover many areas and every element of the Terms of Reference has been addressed in the Report.

We reached our conclusions on the basis of all the evidence we considered. We 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.

Our Report sets out a history of residential childcare in Jersey since 1945, including the policies and practices of different periods and how they were shaped by Jersey's particular circumstances.

In looking at the social, historical and political background of Jersey and when considering other aspects of our remit, including lessons to be learned for the future, we explore what is referred to as "The Jersey Way".

In its most favourable light this expression is said to refer to the maintenance of proud and ancient traditions and preservation of the Island's way of life. Using the expression in a pejorative way it is said to involve the protection of powerful interests and resistance to change, even when change is patently necessary.

In 2008, when the Howard League for Penal Reform reviewed Jersey's youth justice system, they described how, in Jersey, and I quote:

"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." End of quote.

Our view is that the negative impact of “the Jersey Way” has inhibited the prompt development of policy and legislation concerning children.

We considered Jersey’s distinctive structures and approaches to social policy. The absence of a welfare safety net until recent times meant that access to relief depended upon the personal judgement of the local Connetable. We saw no evidence of persons appointed to such a role having any training or particular expertise.

The shortage and cost of housing has had a marked impact on family well-being for some families and the ability of some potential candidates to accommodate foster children. Pressure on accommodation in Jersey has also had a detrimental effect on the ability of relevant departments to recruit and retain suitably qualified and trained staff from outside the Island.

How did Jersey’s care homes operate?

For a long time, in our view, there was no political or professional will in Jersey to set or monitor standards of care for children in respect of whom the States had parental responsibility. In earlier decades there were occasional inspections of States’ care homes by UK Home Office experts. These ceased by the 1970s, and no form of internal inspection replaced them. There were only rare external reviews. In 1981

the report of David Lambert and Elizabeth Wilkinson recommended that Haut de la Garenne be closed, that provision for residential care be reassessed and that resources for preventative care be increased. These recommendations, together with significant recommendations in the later reports of Dr Kathie Bull and Andrew Williamson, were not implemented.

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 promoting standards of care and performance in residential care and no will to invest the resources required in the child care service. People appointed to management roles, often on the basis of local connections, lacked the necessary leadership skills to manage effectively. The consequences for children in care were often devastating and, in many instances, lifelong.

<u>As far as Residential Care is concerned..</u>

We looked at a number of different residential establishments.

Personal experiences of Jersey's care system are at the heart of this Inquiry. We heard many lengthy and often harrowing histories in the course of the evidence. Some appear in the body of the report and all are summarised in Appendix 2. They provide an insight into the lives of children from the 1940s to

the 2000s. On behalf of the Panel I pay tribute to the courage of all those who share their childhood experiences with this Inquiry.

We find that there can be no doubt that many children in the care of the States of Jersey suffered instances of physical abuse, sexual abuse and emotional neglect. This has had far-reaching consequences for many of them, for some throughout their adult lives. Their accounts are essential reading for anyone concerned with the failings of the Jersey child care system.

Let me turn now and deal with our key findings in relation to residential care:

At the Jersey Home for Boys/Jersey Home for Girls there was no regulation of punishments. We heard many accounts of cruel and degrading punishments – children humiliated and beaten with nettles for bedwetting or being locked in confined spaces. Even by the standards of those less enlightened times this approach to punishment was inexcusable and the management and oversight of the homes was deficient.

Qualifications or training were not a requirement for those recruited to senior roles at the Homes. Although the culture changed as staff changed the regimes remained harsh and strictly regimented and the suffering of children did not

diminish. These homes combined in 1959 and then became known as:

Haut de la Garenne

We found that staff at Haut de la Garenne were ill-equipped to deal with the behavioural and emotional needs of children placed in the Home. There was little, if any, staff training. The situation was exacerbated in some periods by a toxic mix of personalities in the staff group who, unchecked, practised or tolerated harsh treatment of children. The extent and nature of that treatment is detailed in the children's accounts, both in the body of the Report and in Appendix 2 and again, I urge you to read them.

Sacre Coeur

As early as 1964, concerns were raised by the Children's Officer about, and I quote, "emotional deprivation", unquote, experienced by children at Sacre Coeur. This orphanage ran for nearly 70 years before there was any form of inspection by the States.

Even by the standards of the time, the regime was abusive, with the emphasis on rigid discipline rather than on nurture.

Such a well-known institution on the Island should have been of interest and concern to the public authority. The States of Jersey should have taken greater responsibility for ensuring that the children at Sacre Coeur were adequately cared for.

Heathfield

When Haut de la Garenne closed in 1986 some children were transferred to Heathfield, others to La Preference.

Recruitment of staff at Heathfield did involve police checks but, as with other establishments, there was insufficient training for staff.

When concerns were raised in 2005 about the operation of the Home, the response of the management was not appropriate and lacked insight. The emphasis remained one of control as opposed to one of care.

La Preference

The lack of interest in the Home shown by Children's Services from the 1950s, when the home was run by the Vegetarian Society, is concerning.

We concluded that Christine Wilson had a positive effect on the culture of the Home from 1971 to 1983. The States took over in 1984 and by the early 2000's there was insufficient funding, there was overcrowding and there were inadequate staffing

levels. In the 21st century it is unacceptable that at times children were sleeping in the living room due to overcrowding.

Brig-y-Don

In our judgment Brig-y-Don succeeded as a voluntary Children's Home because of Margaret Holley's leadership. Staff received supervision and attended training sessions. Children's rights to complain were acknowledged and supported.

States involvement in the governance of Brig-y-Don was adequate while it was a voluntary home. However, we find that once the States took over management and organisation of the Home this was not adequate.

In terms of Foster Care…

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

In 1977 a 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 this approach, common elsewhere, has not been implemented in Jersey.

Some current foster carers painted a disheartening picture of insufficient support, guidance and training for carers; several have ceased fostering because of exhaustion and frustration with the system.

Fundamental to a care system is the basis on which children are taken into residential care and, in turn, the basis on which they are discharged from care

Evidence from Serious Case Reviews conducted in recent years identified ongoing poor assessment practices, 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.

Public authorities in Jersey have a history of paying insufficient regard to the law in relation to children. During Mario Lundy's term of office at Les Chenes, for example a policy was adopted that allowed a child to be admitted for a long-term stay on the imposition of a probation order with a condition of residence at Les Chenes. This approach was a distortion of the purpose of a probation order which is to assist and support young people in the community.

The placement of children in residential facilities reflected the availability of such places on the Island and the lack of

alternatives. There was no consideration of whether the child needs would be better served by remaining with their family. There were cases when the justification for the removal of a child and placement in the care institution were that the child had, and I quote, “behaviour problems”, such as being, and I quote, involved in “petty pilfering”, or was said to be, and I quote, “rude and cheeky”. The draconian intervention of the removal of the child from his or her family paid no regard to the rights and needs of the child.

In 1981 Lambert and Wilkinson noted that there was no statutory provision in Jersey for carrying out preventative childcare. The position remains the same thirty-six years later. The existence of a statutory duty might well have avoided the need for taking some children into care.

There was a pattern of maintaining children in residential homes for an excessively long period. No consideration was given to what therapeutic work was necessary to enable a child to return home.

Children were effectively abandoned in the care system. The mechanism for discharging a child from care was inadequate. Although the States of Jersey had the legislative power to discharge children from care, when it was in the child’s best interests, there was no system for proactive consideration of this power.

When children left the care system in their mid-teens they were again often abandoned without adequate after-care to assist them in making their own way in the world. Many succumbed to exploitation, addiction, crime and depression.

There is little evidence in Jersey of political initiatives to tackle the underlying causes of the social problems known to leave children vulnerable to admission into care. The underlying causes include child poverty, addiction, inadequate housing, mental health issues and social isolation.

An alternative to placement in a children's home was placement in a Family Group Home

By the early 1970s the concept of the Family Group Home was being abandoned across the United Kingdom as unworkable. Jersey continued to develop a model characterised by poor oversight and inadequately trained or poorly supervised staff.

The expectations placed on House parents were too onerous. The House father was expected to look after the children, albeit neither employed by, nor accountable to, Children's Services. Visits by the Child Care Officers were irregular and ad hoc visits by the Children's Officer insufficient. In an island as small as Jersey this is inexplicable and inexcusable.

Clos Des Sables

The management and organisation of Clos des Sables was, we are satisfied, inadequate. Janet Hughes found the role of

Housemother too difficult from the outset. Lesley Hughes, had the care of vulnerable children despite not having received any vetting, training or supervision. He sexually abused children during most of the years of the Home's existence.

Senior staff, including Brenda Chappell, a Senior Child care Officer and Charles Smith, the Children's Officer, left the Hughes to their own devices.

In one Family Group Home that we investigated…

Evidence about the culture of the Home was mixed. Some residents described a tense and controlling atmosphere. One witness referred to it as a "reign of terror". Others, now adults, spoke positively about their time at the home.

In 1975 and 1977 allegations of physical abuse were raised against the Housemother. They were inadequately handled by senior managers and failed the children concerned.

At Norcott Villa

The Children's Sub Committee took decisive action in terminating the employment of the Housemother following adverse reports. This however, is in marked contrast to their handling of allegations at other Family Group Homes and did not lead to more robust oversight at any other Family Group Home.

Blanche Pierre

The operation of Blanche Pierre was and is a testament to the failure of the States management and oversight. Certain children were scapegoated and the accounts of the Houseparents, the Maguires, were sometimes accepted uncritically by social work staff. Jane Maguire limited children's contact with friends and families, which thereby affected their opportunities to tell a trusted adult about conditions in the Home. The Maguires subjected the children to humiliating and

degrading treatment. It was a punitive regime in which certain children were terrorised and abused. The daily routine included beatings, washing of mouth with soap and making children stand in one place for prolonged periods.

Child Care Officers in 1987/1988 recorded Jane Maguire's inability to cope but nothing was done to address this. Brenda Chappell's friendship with Jane Maguire was unprofessional and there was therefore no objective scrutiny of the Home. Concerns raised by Child Care Officers about the Maguires were not heeded at a higher level.

There is no evidence that the Home Diaries of Blanche Pierre were ever inspected. It is astonishing that such a record of flagrantly abusive punishments was maintained and available for inspection. The abuses perpetrated by Jane and Alan Maguire would have been identified much earlier had the diaries been inspected.

I turn now to Les Chenes, which..

combined an Approved School ethos with a remand culture and was a flawed model from its inception. In a 1980 review John Pilling suggested that Les Chenes existed more to meet staff needs than the needs of children.

The decision to run the facility with teaching staff alone, rather than a mix of care and teaching staff, was flawed.

The practice of denying children home visits, sometimes for weeks on end, was unacceptable even by the standards of the time.

The practice of routinely placing children in a secure room, whether they were admitted on remand or as welfare placements, was an unacceptable and ill informed approach to childcare.

Les Chenes was managed in a strict and physically dominant way under both Tom McKeon and Mario Lundy. This, combined with staff ill equipped to provide social care and untrained in the use of physical restraint, resulted at times in the excessive use of force towards the children. This was a failure of management by Mr McKeon and Mr Lundy.

The practice of magistrates from the late 1990s remanding significant numbers of children to Les Chenes, often repeatedly, compounded the problems that the home faced. We are under no illusion as to the difficulties faced by the management but we find that there was a failure of a number of agencies; the school, the Director of Education, the Probation Service, Children's Services and the Courts. These agencies failed to work together to assess and plan to address the needs of individual children.

In her 2001 review of Les Chenes, Dr Kathie Bull highlighted that the problems of overcrowding, hot bedding and the mixing of welfare and remand placements were already evident from 1997. These comprehensive failings, relating to all aspects of the running and management of Les Chenes, are failings that should have been identified earlier.

Dr Bull suggested that the Board of Governors were aware of concerns about Les Chenes over a long period of time but did nothing about them. This included locking up children using what she described as, and I quote, “legally dubious methods”.

The Director of Education, the Education Committee and the Board of Governors failed to exercise proper oversight. This was a significant and inexcusable failing of governance.

The management of Les Chenes under Kevin Mansell was substantially below an adequate standard. In large part the failure of management was due to circumstances beyond the control of Mr Mansell and his staff. They were under enormous pressure and this pressure resulted in poor decision-making, for instance in keeping children in secure cells while staff meetings were taking place and the indiscriminate use of the secure facility. Mr Mansell and his staff were poorly supported by Mr McKeon, then Director of Education.

The August 2003 “riot” was in fact a relatively minor incident of disorder which escalated out of all proportion as a result of poor

handling by staff. The shift leader should have called the Acting Principal, Peter Waggott, before he called the police.

In summary, the ethos of Les Chenes was one of containment and control without any therapeutic focus or attempt to divert young people from offending.

Greenfields

The prison-based “Grand Prix“ behaviour management system, applied between 2003 and 2007, was totally inappropriate.

When social care staff took over the establishment, the changes sought to be implemented by Simon Bellwood were positive and necessary. We endorse his view that children in Jersey did not have a voice, or at least not one that was taken seriously or respected.

The Panel visited Greenfields centre in 2015. The ethos was still one of control and containment. We deprecated the seeming absence of a welfare based approach.

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.

In terms of Political and other oversight of children's homes and of fostering…

We heard evidence from senior elected members who had responsibility for Children's Services under the various governance structures that applied at different times: the Education Committee Children's Subcommittee (1960 to 1995), the Health and Social Services Committee (1995 to 2005) and Ministerial Government from 2006 onwards.

We find that the level of oversight of children's homes by the Education Committee and its successors was inadequate. There was a failure by the various committees and their professional officers to formulate adequate policies or legislation. The Panel see no good reason why the Children (Jersey) Law 1969 was passed over twenty years after its English counterpart and the Children (Jersey) Law 2002 passed over ten years after its counterpart.

Part of the role of oversight should include the commissioning of external inspections. There were NO external inspections of children's homes or children's services for approximately twenty years between the Lambert and Wilkinson Report of 1981 and the first report of Dr Bull in 2001. This is of particular concern given the significant allegations of abuse in three different children's homes between 1989 and 1991. The

allegations were known to Children's Services and yet there was no review, no inspection and no difficult questions asked. This is unacceptable and a further example of inadequate political oversight.

In more recent times, although many reports were commissioned concerning children in care, there was a failure to respond adequately to recommendations made.

We find it deplorable that the States of Jersey has failed to understand its role as "corporate parent" and that Children's Services, and therefore the Island's most vulnerable children, were not given sufficient priority in government funding and attention.

The Board of Governors for Les Chenes and the Board of Visitors for Greenfields did not ensure effective oversight of the way in which these institutions were run and thus failed the children placed there.

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 fact that a Fostering Panel was not established until 2001 is contrary to good practice.

In relation to Children's Services' oversight and operation it was not until 1958 that the first Children's Officer was appointed in Jersey. This was over ten years after the creation of such posts in England.

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

While some recommendations made in commissioned reports have been implemented, many have not, including some of significance. We note also that while child protection guidelines were initially published in 1991 (and subsequently revised) the fact of producing documentation does not keep children safe. Over the following twenty years there was little investment within Children's Services in equipping staff to implement the guidelines effectively.

Changes in and development of childcare practice from 1945 were also considered by the Inquiry…

We provide a chronology of significant changes in childcare practice and policy at Appendix 1 of the Report.

Former minister Ian Le Marquand told us that the priority for the States and the electorate was "and remains" the maintenance of the low tax status. Chief Minister Senator Ian Gorst said that it was unfair to suggest that financial legislation received

greater priority than childcare legislation. Others with experience of the political system disagreed.

We find that the delays in Jersey in adopting good practice and legislation can only be explained by a lack of political and professional will. Traditionally the well-being of vulnerable children has been low on the list of priorities for legislative change and development. We consider that unacceptable.

I turn now to the question of the Reporting of Abuse

Until the 1990s, there is no evidence of any system for victims to Report abuse. The creation of ChildLine in the UK in 1986 did provide an outlet for some children in Jersey to Report abuse. However 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 was in place. The existence of a procedure, however, doesn't mean it works.

Many witnesses said that, as children, they felt unable to report abuse as they felt they would not be believed. Sadly, some children did not recognise their care as being abusive; others

were only able to speak of abusive experiences years later in adult life. For some the experience of becoming a parent caused them to reflect how they were treated as children.

During the early part of the period under review, Jersey society was patrician and hierarchical. Children in care were marginalised. Such attitudes made it more likely that children would not be believed and thus contributed to their fear of coming forward.

What was the response of Education, Health and Social Services to concerns about abuse?

Our Report contains details of many cases of reported abuse. In respect of some, adequate action was taken. We have however identified many failures by staff and management to take appropriate and timely action that might have prevented further abuse.

In the main the responses to allegations of abuse were inadequate. I highlight a few notable cases:-

Morag Jordan bullied and assaulted residents at Haut de la Garenne over a period of more than 10 years. There was no supervision or disciplinary process and no recorded warnings in relation to her known conduct over many years. This was

inexcusable and an inadequate response even taking into account the absence of policies and procedures at the time.

Henry Fleming admitted in August 1975 that he engaged in sexual activity with children from Haut de la Garenne. He was convicted and sentenced to 2 years imprisonment. His sexual assaults on children were known about by August 1975 but only Reported to the Connetable when initial attempts to discourage children from visiting him failed. We consider this was an inadequate response to protect those children from sexual abuse.

During the 1980s a child reported to a staff member that Lesley Hughes had sexually abused her. She was supported by her friend. The staff member took no action. Her evidence was that she thought it was up to the girls to go to the police or someone in Children's Services. We find that to be a completely unacceptable attitude even by the standards of the time. Anton Skinner was advised by a Crown Advocate "to give thought to establishing a fixed policy" but failed to follow up on this advice. Neither did he prepare an in-depth report into what happened as he stated that he would. We find this inexplicable and inexcusable. The Education Department also failed in its duty to take action against the staff member.

The situation at Blanche Pierre where Jane and Alan Maguire perpetrated abuses against children is addressed in detail in

the Report. When the prosecution of Alan Maguire was abandoned in 1999 Dylan Southern was commissioned to produce a report as to whether there was a disciplinary case against Jane Maguire. In the Panel's opinion Anton Skinner's conduct as detailed in the Southern Report, should have been subject to formal investigation.

How did the States of Jersey Police respond to concerns about abuse?

We examined the history of specialist child protection work in the States of Jersey Police from the early Child Protection Team to the current Public Protection Unit.

We recognise that, at times, the child protection unit of the States of Jersey Police was under resourced and was subject to constraints shared by other States of Jersey Police departments. Notably and commendably in 2006 child protection was the only fully staffed unit in the force.

We considered the role of the Honorary Police in the prosecution of child protection cases. In our view, the use of the Honorary Police and the attitude of some Centeniers were a hindrance to justice. The approach to the prosecution of child

abuse cases was not sufficiently robust and led to a lack of confidence in victims and other professionals in the prosecution system. 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 States of Jersey Police and Children Services also had concerns about the response of the Honorary Police to cases of child abuse, child neglect and domestic violence; a lenient view was often taken of such serious cases. These cases are now rightly the exclusive responsibility of the States of Jersey Police.

These matters should have been addressed much earlier in Jersey's history, given the dual role of the Attorney General in leading the Island's prosecution service and leading the Honorary Police,

The Report considers in detail many cases investigated during Operation Rectangle which was undertaken between 2007 and 2010. We conclude these investigations were all appropriately managed by the States of Jersey Police.

<u>I turn now to Operation Rectangle itself</u>

Operation Rectangle was the first States of Jersey Police operation into historical child abuse. We describe the investigation from its covert stage in 2007 through to its conclusion in 2010.

In terms of political involvement in Operation Rectangle politicians did not grasp the urgency and importance of the investigation, or the need to prepare for media and public interest and scrutiny. We conclude that the initial lethargic political response was due to this failure rather than any attempt to impede the investigation.

We note that the evidence of Lenny Harper, Deputy Chief Officer, was 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 reputation. Mr Walker refuted this and 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.

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

We find that Senator 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.

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

A great deal of media attention was generated by the States of Jersey Police 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 Haut de la Garenne. 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.

Chief Officer Graham Power accepted that more should have been done to correct inaccurate press reporting. The Inquiry has seen correspondence and notes of meetings involving politicians, the Attorney General, Graham Power and Lenny Harper in which the Attorney General urged politicians not to intervene in the police investigation. He also sought to persuade the States of Jersey Police to correct inaccurate reporting.

On 27 March 2008, the Council of Ministers announced that a public Inquiry would take place at the conclusion of any criminal proceedings.

The public perception at that time was, we believe, succinctly summarised in the submissions to this Inquiry by the Jersey Care Leavers Association:

"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."

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."

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. However, 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.

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 are satisfied that Frank Walker and the majority of politicians accepted the strong advice of the Attorney General and did not seek actively to interfere. 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.

We looked at the difficulties in the relationship between the States of Jersey Police and the Law Officers' Department during the course of Operation Rectangle insofar as they impacted on the investigation and prosecution of cases of the abuse of children in care.

We 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 often hysterical and inaccurate media reporting of the progress of the Police investigation.

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 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.

We have seen nothing 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.

Following Mr Harper's retirement, the arrival from the UK of experienced senior officers; acting Chief Officer David Warcup

and Chief Officer Michael Gradwell, clearly improved the working atmosphere. 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 Alison Fossey and her colleagues pursued investigations, including their efforts to track down former Jersey care home residents to ensure that all were accounted for.

The suspension of Graham Power

In November 2008, Graham Power, then the Chief Officer of Police, was suspended by the then Home Affairs Minister, Andrew Lewis. The reasons given related to alleged failings in the management of Operation Rectangle.

We set out in the Report the detailed sequence of events leading to Mr Power's suspension, including the concerns of the Law Officers' Department 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 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.

Those responsible for Mr Power's suspension did not heed the advice of the Solicitor General or the Attorney General. They were told about the risks of relying on an interim report by the Metropolitan Police Service into the management of Operation Rectangle. They were advised that they needed to show to Graham Power any report on which they were relying and to give him the chance to comment on it.

We accept the evidence of the then Attorney General, William Bailhache QC, who understood that the decision to suspend Graham Power had already been made by the evening of 11 November 2008, in advance of the meeting with Mr Ogley and Andrew Lewis the following day.

It is clear to us that when Graham Power attended the meeting on 12 November 2008, his suspension was inevitable.

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.

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

It was clear that Operation Rectangle was going to continue with or without Graham Power's presence.

We commend the States of Jersey Police 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.

I turn now to the probity of the decision making process as to whether or not cases should be prosecuted

We set out the detail of the procedures regarding prosecution that were put in place for Operation Rectangle. We found that the approach of the States of Jersey Police 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 States of Jersey Police, 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 independent leading counsel in London Nicholas Griffin QC reviewed for us 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.

In each of these cases we found that the decision-making process was carried out professionally and appropriately.

In relation to current services for children, foster carers told us in 2016, and I quote,: *“The service is failing our children, leaves them very vulnerable and has not learned any lessons whatsoever no matter how many Serious Case Reviews have occurred.”*

Interim managers arriving in 2014 found a management style within the residential sector, which was, and I quote, "*not conducive to keeping children safe*". Young people currently in the care system told us that they feel that they have no

effective mechanism for making representations or raising concerns.

We heard that lessons of the past have not been learned over long periods because of what was described as 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 Lesley Hughes at Blanche Pierre first came to light.

In the light of all the evidence that we 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.

The current picture is not entirely bleak. We found enormous resources of goodwill and generosity in Jersey, and many people with a passionate commitment to the Island's children. They were developing resources and supporting 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.

<u>We have enumerated, in the Report, eight lessons that Jersey has to learn</u>

(i) **The welfare and interests of children are paramount and trump all other considerations.**

(ii) **Give children a voice – and then listen to it.** For too long children have been unable or unwilling to speak, fearful of the consequences and having no confidence that anything they say will make any difference.

(iii) **Be clear about what services are trying to do and the standards which they should attain.**

(iv) **Independent scrutiny is essential**.

(v) **Stay connected** with developments in the rest of the civilised world in the fields of child care and youth justice.

(vi) **Investment is essential.** And Jersey must be prepared to invest in its children.

(vii) **Quality of leadership and professionalism are fundamental requirements.**

(viii) **Openness and transparency must characterise the culture of public services.** The establishment of this Inquiry and the freedom with which we have been allowed to operate has demonstrated a political will and public desire to open Jersey's institutions to thorough, independent and robust scrutiny in order to serve the best interests of children.

Our 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.

RECOMMENDATION 1: A Commissioner for Children

To ensure independent oversight of the interests of children and young people in Jersey. In order to achieve and maintain public confidence in this work the commissioner must be and be seen to be independent.

RECOMMENDATION 2: Giving children and young people a voice

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.

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.

RECOMMENDATION 3: Inspection of services

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.

RECOMMENDATION 4: Building a sustainable workforce

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.

RECOMMENDATION 5: Legislation

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 recommend therefore that the youth justice system move to a model that always treats young offenders as children first and offenders second.

RECOMMENDATION 6: Corporate parent

The corporate parent is an important concept in social policy, and it is essential that all those with this responsibility understand and are equipped to fulfil those responsibilities.

RECOMMENDATION 7: The "Jersey Way"

This was well summarised in the contribution of a Phase 3 witness who told us, and I quote:

"*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."*

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.

RECOMMENDATION 8: Legacy issues

Finally, Jersey must consider a number of legacy issues.

1. All of the Inquiry's vast documentation should be preserved in perpetuity. 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 in our view, material should not be transferred until such time as we are satisfied that the arrangements will afford it proper protection.

2. We also recommend that there is some form of tangible public acknowledgement, for example by way of memorial or plaque, of those who have been ill served by the care system over many decades. 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.

3. We believe that the buildings at Haut de la Garenne are a reminder of an unhappy past or shameful history for many people. We recommend that consideration be given as to how the buildings can be demolished. 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.

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.

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.

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 often harrowing 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. We therefore recommend that arrangements for ongoing support are put in place for those who may feel they need it.

A fair test of any society is how it treats its most vulnerable citizens. Jersey is no exception. We trust that the recommendations we make will set future policy so that all children in Jersey, irrespective of their circumstances, are nurtured and protected and given every chance to flourish.